Supreme Court, U.S.

(1)

No. 95-98 JUL 18 1995

In The

Supreme Court of the United States

October Term, 1995

HILLSBOROUGH COUNTY HOSPITAL AUTHORITY, *et al.*,

Petitioners,

vs.

DONNA E. SHALALA, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

Whether the "special circumstances" adjustments mandated under 42 U.S.C. §1395ww(b)(4)(A) are applicable to the calculation of the hospital-specific portion of a hospital's Medicare reimbursement under 42 U.S.C. §1395ww(d) during the four year transition period under Medicare's prospective payment system.

LIST OF ALL PARTIES TO THE PROCEEDINGS[1]

Adventist Health System/Sun Belt, Inc. d/b/a Florida Hospital

Parent Company: None

Subsidiaries/Affiliates: East Pasco Medical Center; Florida Hospital Altamonte; Florida Hospital Apopka; Florida Hospital East Orlando; Florida Hospital Kissimmee; Florida Hospital Lake Placid; Florida Hospital Waterman; Florida Hospital Wauchula; Volusia Medical Center

Adventist Health System/Sun Belt, Inc. d/b/a Medical Center Hospital

Parent Company: None

Subsidiaries/Affiliates: East Pasco Medical Center; Florida Hospital Altamonte; Florida Hospital Apopka; Florida Hospital East Orlando; Florida Hospital Kissimmee; Florida Hospital Lake Placid; Florida Hospital Waterman; Florida Hospital Wauchula; Volusia Medical Center

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[1] **Rule 29.1 Listing**: The parent companies and subsidiaries/affiliates of the 114 Petitioners, to the extent they have been ascertained, are listed in conjunction with the List of All Parties to the Proceedings. We are in the process of obtaining the remainder of the names of parent companies and subsidiaries/affiliates of the 114 Petitioners. Because of the number of Petitioners, and because most, if not all of the Petitioners have parent companies and/or subsidiaries, we were unable to complete this formidable task within the time restraints for filing this Petition. We will file lists with the required information as soon as it is obtained and compiled.

Adventist Health System/Sun Belt Inc. d/b/a Walker Memorial Hospital
Parent Company: None
Subsidiaries/Affiliates: East Pasco Medical Center; Florida Hospital Altamonte; Florida Hospital Apopka; Florida Hospital East Orlando; Florida Hospital Kissimmee; Florida Hospital Lake Placid; Florida Hospital Waterman; Florida Hospital Wauchula; Volusia Medical Center

Baptist Hospital, Inc. d/b/a Baptist Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates (not already listed as Petitioner):

Baptist Hospital of Miami, Inc. d/b/a Baptist Hospital of Miami
Parent Company: Baptist Health System
Subsidiaries/Affiliates: Mariners Hospital, Tavernier; SMH Homestead Hospital; South Miami Hospital

Baptist Medical Center d/b/a Baptist Medical Center-Beaches
Parent Company: Baptist/St. Vincent's Health System
Subsidiaries/Affiliates: Baptist Medical Center (Jacksonville); Baptist Medical Center-Nassau, Fernandina Beach; Riverside Hospital (Jacksonville) (also part of Daughters of Charity); St. Vincent's Medical Center (Jacksonville) (also part of Daughters of Charity); Wolfson Children's Hospital (Jacksonville)

Baptist Regional Health Services, Inc., d/b/a Jay Hospital
Parent Company: Baptist Health Care, Inc.
Subsidiaries/Affiliates: Baptist Hospital (Pensacola); Gulf Breeze Hospital, Inc.

Bartow Memorial Hospital, Inc., d/b/a Bartow Memorial Hospital

Parent Company: Quorum Health Resources

Subsidiaries/Affiliates: Bascom Palmer Eye Institute; Bert Fish Medical Center; Brooksville Regional Hospital; DeSoto Memorial Hospital, Inc.; Glades General Hospital; Hendry General Hospital; Hialeah Hospital; Jackson Hospital; Jupiter Medical Center; Leesburg Regional Medical Center; South Lake Memorial Hospital, Inc.; Spring Hill Regional Hospital; University of Miami Hospital/Clinic

Bay Hospital, Inc. d/b/a HCA Gulf Coast Comm.

Parent Company: (Information not available)

Subsidiaries/Affiliates: (Information not available)

Bayfront Medical Center, Inc., d/b/a Bayfront Medical Center

Parent Company: (Information not available)

Subsidiaries/Affiliates: (Information not available)

Bethesda Memorial Hospital, Inc. d/b/a Bethesda Memorial Hospital

Parent Company: (Information not available)

Subsidiaries/Affiliates: (Information not available)

Big Sun Healthcare Systems, Inc., d/b/a Monroe Regional Medical Center

Parent Company: (Information not available)

Subsidiaries/Affiliates: (Information not available)

Board of Commissioners of Halifax Medical Center d/b/a Halifax Medical Center

Parent Company: (Information not available)

Subsidiaries/Affiliates: (Information not available)

Boca Raton Community Hospital, Inc. d/b/a Boca Raton Community Hospital
Parent Company: BRCH Corporation
Subsidiaries/Affiliates: BRCH Foundation, Inc.; BRCH Home Health Service, Inc.; BRCH Imaging, Inc.; BRCH Health Plans, Inc.; BRCH Properties, Inc.

Cape Coral Medical Center, Inc. d/b/a Cape Coral Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Cedars Medical Center, Inc., d/b/a Cedars Medical Center
Parent Company: Columbia/HCA South Florida Division
Subsidiaries/Affiliates: Aventura Hospital & Medical Center; Columbia Hospital (West Palm Beach); Deering Hospital (Miami); Kendall Regional Medical Center (Miami); Miami Heart Institute, Inc.; Northwest Regional Medical Center (Margate); Palm Beach Regional Hospital (Lake Worth); Palms West Hospital (Loxahatchee); Pembroke Pines Hospital; Plantation General Hospital; Pompano Beach Medical Center; University Hospital - Tamarac; University Pavillion Hospital (Tamarac); Victoria Pavillion (Miami); Westside Regional Medical Center (Plantation)

Central FL Reg. d/b/a Central FL Reg.
Parent Company: Columbia/HCA Central Florida Division
Subsidiaries/Affiliates: Columbia Park Medical Center (Orlando); Daytona Medical Center (Daytona Beach); Lawnwood Pavilion (Ft. Pierce); Lawnwood Regional Medical Center (Ft. Pierce); Medical Center/Port St. Lucie; Osceola Regional Hospital (Kissimmee); Psychiatric Care Center (Winter Park); Raulerson Hospital (Okeechobee); South Seminole

Hospital (Longwood); Winter Park Memorial Hospital

CHS Management Corporation d/b/a University General Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

CHS Management Corporation d/b/a Women's Medical Center (Lake Seminole)
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

City of Homestead d/b/a James Archer Smith Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Clearwater Community Hospital Limited Partnership d/b/a Clearwater Community Hospital
Parent Company: Columbia/HCA Tampa Bay Division
Subsidiaries/Affiliates: Brandon Hospital; Columbia Hospital of New Port Richey; Columbia Regional Medical Center at Bayonet Point (Hudson); Columbia/HCA Oak Hill Community Hospital (Springhill); Dade City Hospital; Edward White Hospital (St. Petersburg); L.W. Blake Hospital (Bradenton); Largo Medical Center; Northside Hospital (St. Petersburg); South Bay Hospital (Sun City Center); St. Petersburg General Hospital

Cleveland Clinic Florida Hospital d/b/a North Beach Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Community Hospital of Humana, Inc., d/b/a Humana Hospital-Cypress
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Community Hospital of the Palm Beaches, Inc. d/b/a Humana Hospital-Palm Beaches
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

DeSoto Memorial Hospital, Inc. d/b/a DeSoto Memorial Hospital[2]
Parent Company: Quorum Health Resources
Subsidiaries/Affiliates: Bartow Memorial Hospital; Bascom Palmer Eye Institute; Bert Fish Medical Center; Brooksville Regional Hospital; Glades General Hospital; Hendry General Hospital; Hialeah Hospital; Jackson Hospital; Jupiter Medical Center; Leesburg Regional Medical Center; South Lake Memorial Hospital, Inc.; Spring Hill Regional Hospital; University of Miami Hospital/Clinics

Doctors General Hospital, Ltd., d/b/a Universal Medical Center
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Doctors Hospital of Sarasota, Ltd. d/b/a Doctors Hospital of Sarasota
Parent Company: Columbia/HCA S.W. Florida Division
Subsidiaries/Affiliates: East Point Hospital; Englewood Community Hospital, Inc.; Fawcett Memorial

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2 Managed by Quorum Health Resources.

Hospital; Gulf Coast Hospital; Southwest Florida Regional Medical Center

Doctors Mercy Hospital, Ltd., d/b/a AMI Medical Center Orlando (Brookwood Community Hospital)
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Dr. John T. MacDonald Foundation d/b/a Doctor's Hospital of Coral Gables
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

HCA Health Services of Florida, Inc. d/b/a Bayonet Point Hospital
Parent Company: Columbia/HCA Tampa Bay Division
Subsidiaries/Affiliates: Brandon Hospital; Clearwater Community Hospital; Columbia Hospital of New Port Richey; Columbia/HCA Oak Hill Community Hospital (Springhill); Dade City Hospital; Edward White Hospital (St. Petersburg); Largo Medical Center; Northside Hospital (St. Petersburg); South Bay Hospital (Sun City Center); St. Petersburg General Hospital

HCA Health Services of Florida, Inc. d/b/a L.W. Blake Memorial Hospital
Parent Company: Columbia/HCA Tampa Bay Division
Subsidiaries/Affiliates: Brandon Hospital; Clearwater Community Hospital; Columbia Hospital of New Port Richey; Columbia Regional Medical Center at Bayonet Point (Hudson); Columbia/HCA Oak Hill Community Hospital (Springhill); Dade City Hospital; Edward White Hospital (St. Petersburg); Largo Medical Center; Northside Hospital (St.

Petersburg); South Bay Hospital (Sun City Center); St. Petersburg General Hospital

HCA Health Services of Florida, Inc. d/b/a HCA North Florida Medical Center

Parent Company: Columbia/HCA North Florida Division

Subsidiaries/Affiliates: Ft. Walton Beach Medical Center; Gulf Coast Hospital (Panama City); Hamilton County Memorial Hospital (Jasper); Lake City Medical Center; Mariane Community Hospital (Ocala); North Okaloosa Medical Center (Crestview); Putnam Community Hospital (Palatka); Santa Rosa Medical Center (Milton); Tallahassee Community Hospital; Twin Cities Hospital (Niceville); West Florida Regional Medical Center (Pensacola)

HCA Health Services of Florida, Inc. d/b/a HCA Northwest Regional Hospital

Parent Company: Columbia/HCA South Florida Division

Subsidiaries/Affiliates: Aventura Hospital & Medical Center; Cedars Medical Center; Columbia Hospital (West Palm Beach); Deering Hospital (Miami); Kendall Regional Medical Center (Miami); Miami Heart Institute (Miami Beach); Palm Beach Regional Hospital (Lake Worth); Palms West Hospital (Loxahatchee); Pembroke Pines Hospital; Plantation General Hospital; Pompano Beach Medical Center; University Hospital - Tamarac; University Pavillion Hospital (Tamarac); Victoria Pavillion (Miami); Westside Regional Medical Center (Plantation)

Hillsborough County Hospital Authority d/b/a Tampa General Hospital

Parent Company: None

Subsidiaries/Affiliates: TGH University Psychiatry Center; Tampa General Hospital

Holmes Regional Medical Center, Inc. d/b/a Holmes Regional Medical Center
Parent Company: None
Subsidiaries/Affiliates: Palm Bay Community Hospital

Holy Cross Hospital, Inc. d/b/a Holy Cross Hospital
Parent Company: Eastern Mercy Health System
Subsidiaries/Affiliates: None

Hospital, Inc. d/b/a AMI Beach Gardens Medical Center
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Hospital Board of Directors of Lee County d/b/a/ Lee Memorial Hospital
Parent Company: None
Subsidiaries/Affiliates: Lee Memorial/Health Park Medical Center

Hospital Corp of AME d/b/a HCA Twin Cities Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Humana, Inc. d/b/a Humana Hospital-Sebastian
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Humana, Inc. d/b/a Humana Hospital-South Broward
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Humana, Inc. d/b/a Humana Hospital-Biscayne
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Humana of Florida, Inc. d/b/a Humana Hospital-Bennett
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Humana of Florida, Inc. d/b/a Humana Hospital-Daytona Beach
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Humana of Florida, Inc. d/b/a Humana Hospital-Ft. Walton Beach
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Humana of Florida, Inc. d/b/a Humana Hospital-Kissimmee
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Humana of Florida, Inc. d/b/a Humana Hospital-Lucerne
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Humana of Florida, Inc. d/b/a Humana Hospital-Orange Park
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Humana of Florida, Inc. d/b/a Humana Hospital-Pasco
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Humana of Florida, Inc. d/b/a Humana Hospital-St. Petersburg
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Humana of Florida, Inc. d/b/a Humana Women's Hospital-Tampa
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Humbosco, Inc. d/b/a Humana Hospital-Northside
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Humhosco, Inc. d/b/a Humana Hospital-Brandon
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

JFK Medical Center, Inc. d/b/a JFK Medical Center
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Jupiter Hospital, Inc. d/b/a Jupiter Hospital
Parent Company: Quorum Health Resources
Subsidiaries/Affiliates: Bartow Memorial Hospital; Bascom Palmer Eye Institute; Bert Fish Medical Center; Brooksville Regional Hospital; DeSoto Memorial Hospital, Inc.; Glades General Hospital; Hendry General Hospital; Hialeah Hospital; Jackson Hospital; Leesburg Regional Medical Center; South Lake Memorial Hospital, Inc.; Spring Hill Regional Hospital; University of Miami Hospital/Clinics

Kissimmee Memorial Hospital, Inc., d/b/a Kissimmee Memorial Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Lake Wales Hospital Association, Inc. d/b/a Lake Wales Hospital Association, Inc.
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Lakeland Regional Medical Center, Inc., d/b/a Lakeland Regional Medical Center
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Largo Medical Center Hospital, Inc. d/b/a HCA Marion Community Hospital
Parent Company: Columbia/HCA Tampa Bay Division
Subsidiaries/Affiliates: Brandon Hospital; Clearwater Community Hospital; Columbia Hospital of New Port Richey; Columbia Regional Medical Center at Bayonet Point (Hudson); Columbia/HCA Oak Hill Community Hospital (Springhill); Dade City Hospital; Edward White Hospital (St. Petersburg); L.W. Blake Hospital (Bradenton); Northside Hospital (St. Petersburg); South Bay Hospital (Sun City Center); St. Petersburg General Hospital

Leesburg Regional Medical Center, Inc., d/b/a Leesburg Regional Medical Center, Inc.
Parent Company: Quorum Health Resources
Subsidiaries/Affiliates: Bartow Memorial Hospital; Bascom Palmer Eye Institute; Bert Fish Medical Center; Brooksville Regional Hospital; DeSoto Memorial Hospital, Inc.; Glades General Hospital; Hendry General Hospital; Hialeah Hospital; Jackson Hospital; Jupiter Medical Center; South Lake Memorial Hospital, Inc.; Spring Hill Regional Hospital; University of Miami Hospital/Clinics

Lifemark Hospitals of Florida, Inc. d/b/a AMI Palmetto General Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Lower Florida Keys Health System, Inc. d/b/a Depoo Hospital
Parent Company: None
Subsidiaries/Affiliates: Health System Florida Keys and Depoo

Manatee Hospitals & d/b/a Manatee Memorial Hospital
Parent Company: Universal Health Services, Inc.
Subsidiaries/Affiliates: THC-Hollywood; Transitional Hospital of Tampa; Universal Medical Center; Wellington Regional Medical Center

Memorial Hospital of Tampa, Inc. d/b/a Memorial Hospital of Tampa
Parent Company: Tenet Healthcare Corporation
Subsidiaries/Affiliates: Delray Community Hospital; Hollywood Medical Center; North Ridge Medical Center; Palm Beach Gardens Medical Center; Palmetto General Hospital; Palms of Pasadena Hospital; Pinecrest Rehabilitation Hospital at Delray; Seven Rivers Community Hospital; Town and Country Hospital; West Boca Medical Center

Memorial Hospital-Flagler, Inc. d/b/a Memorial Hospital
Parent Company: Memorial Health Systems
Subsidiaries/Affiliates: Memorial Hospital (Ormond Beach); Memorial Hospital (West Volusia)

Mercy Hospital, Inc. d/b/a Mercy Hospital
Parent Company: Daughters of Charity
Subsidiaries/Affiliates: Riverside Hospital (Jacksonville); Sacred Heart Hospital Pensacola; St. Vincent's Hospital (Jacksonville)[3]

Methodist Hospital, Inc. d/b/a Methodist Medical Center
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Miami Heart Institute, Inc., d/b/a Miami Heart Institute
Parent Company: Columbia/HCA South Florida Division
Subsidiaries/Affiliates: Aventura Hospital & Medical Center; Cedars Medical Center; Columbia Hospital (West Palm Beach); Deering Hospital (Miami); Kendall Regional Medical Center (Miami); Northwest Regional Medical Center, (Margate); Palm Beach Regional Hospital (Lake Worth); Palms West Hospital (Loxahatchee); Pembroke Pines Hospital; Plantation General Hospital; Pompano Beach Medical Center; University Hospital - Tamarac; University Pavillion Hospital (Tamarac); Victoria Pavillion (Miami); Westside Regional Medical Center (Plantation)

Morton F. Plant Hospital Association, Inc. d/b/a Morton F. Plant Hospital
Parent Company: Morton Plant/Mease Health Care
Subsidiaries/Affiliates: Mease Hospital (Countryside, Safety Harbor); Mease Hospital (Dunedin)

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[3] Riverside Hospital and St. Vincent's Hospital are also part of Baptist/St. Vincent's Health System.

Mount Sinai Hospital of Greater Miami, Inc., d/b/a Mount Sinai Medical Center

Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

National Medical Enterprises d/b/a Delray Community Hospital

Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

New Port Richey Hospital, Inc. d/b/a HCA New Port Richey Hospital (Community Hospital of New Port Richey)

Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

NME Hospital, Inc. d/b/a Hollywood Medical Center

Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

NME Hospital, Inc. d/b/a Palms of Pasadena Hospital

Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

NME Hospital, Inc. d/b/a Steven Rivers Community Hospital

Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

North Brevard County Hospital District d/b/a Jess Parrish Medical Center

Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

North Broward Hospital, North Broward Hospital District d/b/a Broward General Medical Center
Parent Company: None
Subsidiaries/Affiliates: Coral Springs Medical Center; Imperial Point Medical Center (Ft. Lauderdale)

North Broward Hospital d/b/a Imperial Point Medical Center
Parent Company: North Broward Hospital District
Subsidiaries/Affiliates: Coral Springs Medical Center

North Broward Hospital d/b/a North Broward Medical
Parent Company: North Broward Hospital District
Subsidiaries/Affiliates: Coral Springs Medical Center; Imperial Point Medical Center (Ft. Lauderdale)

North Miami Medical Center, Ltd., d/b/a Parkway Regional Medical Center
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

North Shore Medical Center, Inc., d/b/a North Shore Medical Center
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Notami Hospitals of Florida, Inc. d/b/a Lake City Medical Center
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Orlando Regional Medical Center, Inc. d/b/a Orlando Regional Medical Center
Parent Company: Orlando Regional Healthcare System
Subsidiaries/Affiliates: Arnold Palmer Hospital for Children & Woman; Sand Lake Hospital; South Seminole Hospital; St. Cloud Hospital

Palm Beach Gardens Community Hospital, Inc. d/b/a AMI Beach Gardens Medical Center
Parent Company: Tenet Healthcare Corporation
Subsidiaries/Affiliates: Delray Community Hospital; Hollywood Medical Center; Memorial Hospital of Tampa; North Ridge Medical Center; Palmetto General Hospital; Palms of Pasadena Hospital; Pinecrest Rehabilitation Hospital at Delray; Seven Rivers Community Hospital; Town & Country Hospital; West Boca Medical Center

Pan American Hospital d/b/a American Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Public Health Trust of Dade County d/b/a Jackson Memorial Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Riverside Hospital, Inc., d/b/a Riverside Hospital
Parent Company: Daughters of Charity
Subsidiaries/Affiliates: Sacred Heart Hospital of Pensacola; St. Vincent's Hospital; Mercy Hospital

Saint Anthony's Hospital, Inc. and Saint Anthony's Health Care Center, d/b/a/ Saint Anthony's Hospital
Parent Company: Allegany Health System
Subsidiaries/Affiliates: St. Joseph's Hospital; St. Joseph's Women's Hospital; St. Mary's Hospital

Shands Teaching Hospital & Clinics, Inc. d/b/a Shands Teaching Hospitals and Clinics
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

South Florida Baptist Hospital, Inc. d/b/a South Florida Baptist Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

South Miami Hospital, Inc., d/b/a South Miami Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Southeast Community Health Services, Inc., d/b/a Doctors' Memorial Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Southeast Community Health Services, Inc., d/b/a Gadsden Memorial Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Southeastern Medical Center, Hospital Contractors, Ltd., d/b/a AMI Town & Country Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Southwest Florida Regional Medical Center, Inc., d/b/a Southwest Florida Regional Medical Center (Ft. Myers Community)
Parent Company: Columbia/HCA S.W. Florida Division
Subsidiaries/Affiliates: Doctors Hospital of Sarasota, Inc.; East Pointe Hospital; Englewood Community Hospital; Fawcett Memorial Hospital; Gulf Coast Hospital;

St. Francis Hospital, Inc., d/b/a St. Francis Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

St. Joseph Hospital of Port Charlotte, Florida, Inc., d/b/a St. Joseph Hospital of Port Charlotte
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

St. Luke's Hospital Association d/b/a St. Luke's Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

St. Mary's Hospital, Inc., d/b/a St. Mary's Hospital
Parent Company: Allegany Health System (also part of Intracoastal Health System)
Subsidiaries/Affiliates: St. Anthony's Hospital, Inc.; St. Joseph's Hospital, Inc.; St. Joseph's Women's Hospital; Good Samaritan Medical Center

St. Vincent's Medical Center, Inc., d/b/a St. Vincent's Medical Center
Parent Company: Daughters of Charity
Subsidiaries/Affiliates: Mercy Hospital; Riverside Hospital; Sacred Heart Hospital of Pensacola

Tallahassee Medical Center, Inc. d/b/a Tallahassee Community Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Tallahassee Memorial Regional Medical Center, Inc., d/b/a Tallahassee Memorial Regional Medical Center
Parent Company: Columbia/HCA North Florida Division
Subsidiaries/Affiliates: Fort Walton Beach Medical Center; Gulf Coast Hospital; Hamilton County

Memorial Hospital; Lake City Medical Center; Marion Community Hospital; North Florida Regional Hospital; North Okaloosa Medical Center; Putnam Community Hospital; Santa Rosa Medical Center; Twin Cities Hospital; West Florida Regional Medical Center

Trustees of Mease Hospital, Inc. d/b/a Mease Hospital Dunedin
Parent Company: Morton Plant/Mease Health Care
Subsidiaries/Affiliates: Mease Hospital/Countryside, Safety Harbor; Mease Hospital/Dunedin

University Medical Center d/b/a University Medical Center of Jacksonville
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

University of Miami, Inc. d/b/a Anne Bates Leach Eye Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Victoria Hospital Partnership d/b/a Victoria Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Washington County Board of County Commissioners d/b/a
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Northwest Florida Community Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

West Orange Memorial Hospital Tax District d/b/a West Orange Memorial Hospital
Parent Company: (Information not available)
Subsidiaries/Affiliates: (Information not available)

Winter Haven Hospital, Inc., d/b/a Winter Haven Hospital
Parent Company: Mid-Florida Medical Services
Subsidiaries/Affiliates: Lake Wales Medical Center, Inc.; Morrow Memorial Hospital; Regency Medical Center

TABLE OF CONTENTS

Page

QUESTION PRESENTED FOR REVIEW ii

LIST OF ALL PARTIES TO THE PROCEEDINGS iii

RULE 29.1 LISTING iii

TABLE OF CONTENTS xxiv

TABLE OF AUTHORITIES xxvi

INDEX TO APPENDIX XXX

OPINIONS BELOW 2

STATEMENT OF JURISDICTION 2

STATUTES AND REGULATIONS INVOLVED 3

STATEMENT OF THE CASE 3

A. Factual Background 3

B. History of the Statute 4

C. Indigent Health Care Program Assessment 7

D. Proceedings Below 7

REASONS FOR GRANTING THE WRIT 8

A. To Settle a Controversy Among the Circuits Over a Significant Legal Issue of Continuing Importance 8

1. Secretary's Interpretation Under the *Chevron* Analysis 10

2. The Error of the Secretary's Interpretation of Subsection (b)(4)(A) 10

3. Chandler 12

4. Sacred Heart and Episcopal 13

5. District Court Decisions 14

6. Question of Continuing Importance 15

B. To Prevent the Propagation of Mistakes and to Clarify the Appropriate Standard of Deference to Be Given Agency Interpretation 16

1. Legislative History 17

2. The Secretary's Changing Position 18

CONCLUSION 20

TABLE OF AUTHORITIES

Page

CASES

Andrus v. Glover Construction Company,
446 U.S. 608, 617 (1980) 10

Board of Governors of the Fed. Reserve Sys. v. Dimension Fin. Corp.,
474 U.S. 361 (1986) 10

Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.,
467 U.S. 837 (1984) 10, 12, 13, 14, 15, 16, 19

Community Hosp. of Chandler, Inc. v. Sullivan,
963 F.2d 1206 (9th Cir. 1992) 9, 12, 13, 14

Episcopal Hosp. v. Shalala, 994 F.2d 879
(D.C. Cir. 1993), *cert. denied*,
No. 93-429, 62 U.S.L.W. 3468
(Jan. 18, 1994) 9, 14, 15, 16, 19

Florida and American Medical Assoc., Inc. v. Department of Health, Education and Welfare, 479 F. Supp. 1291
(M.D. Fla. 1979) 11

General Care Corp. v. Sullivan, No. 92-1326 15

Good Samaritan Hosp., et al., v. Shalala,
113 S.Ct. 2151 (1993) 16, 19

Good Samaritan Hosp. Regional Medical Center v. Shalala, No. 92-8726 16

Greenville Hosp. Sys. v. Heckler,
642 F. Supp. 15 (D.S.C. 1985) 15, 19

HCA Services of Texas v. Sullivan, No. 92-1324 15

Hospital Corporation of Tennessee v. Sullivan, No. 92-1325 15

Hillsborough County Hosp. Auth. v. Shalala,
49 F.3d 1516 (11th Cir. 1995) 2

Hospital Corp. of Tennessee v. Sullivan,
No. 92-1325 15

Motor Vehicles Manufacturers Association v. State Farm Mutual Automobile Insurance Company, 463 U.S. 29 (1983) 19

Newport Hospital and Clinic, Inc. v. Sullivan,
Medicare and Medicaid Guide (CCH)
¶38,844 (D.D.C. Sept. 24, 1990) 15

Nyack Hospital v. Sullivan, No. 92-0455 15

Okeechobee Hospital v. Sullivan, No. 92-1323 15

Redbud Hospital District v. Heckler, Medicare and Medicaid Guide (CCH) ¶34,085 (N.D. Cal. July 30, 1984), *vacated on other grounds*, 473 U.S. 1308 (1985) 15, 19

Sacred Heart Medical Ctr. v. Sullivan, 958 F.2d 537 (3rd Cir. 1992) 9, 12, 13, 14, 15, 16, 19

Sunshine Health Sys., Inc. v. Bowen,
809 F.2d 1390 (9th Cir. 1987) 13

The Methodist Hospital v. Sullivan, Medicare and Medicaid Guide (CCH) ¶39,627 (D.D.C. Sept. 20, 1991), *reversed*, 6 F.3d 829 (D.C. Cir. Sept. 16, 1993), *cert. denied*, No. 93-1449, 114 S.Ct. 2162 (June 6, 1994) 9, 15

STATUTES

28 U.S.C. §1254(1) 2

42 U.S.C. §1395oo(f) 2, 8

42 U.S.C. §1395(g) 3

42 U.S.C. §1395ww(a) 10

42 U.S.C. §1395ww(b) ..... 4, 5, 9, 10,11, 12 ..... 13, 14, 16, 18, 19

42 U.S.C. §1395ww(d) 4, 6, 11, 13

42 U.S.C. §1395x(v) 4

Florida Statutes §395.101 (1985) 7

Florida Statutes §409.2662(1) (1985) 7

REGULATIONS

42 C.F.R. §405.1842 2

42 C.F.R. §412.71 6

42 C.F.R. §412.72 6

49 Fed. Reg. 261 18

MISCELLANEOUS

Fed. R. App. P. 4(a)(1) 8

Sup. Ct. R. 10 8

S. Rep. No. 23, 98th Cong., 1st Sess. 53,
reprinted in 1983 U.S. Code Cong. & Admin.
News 143, 193 6

H.R. Rep. No. 760, 97th Congress, 2d Sess. 420 18

APPENDICES

Page

Appendix A - Opinion of the United States Court of Appeals, Eleventh Circuit, Dated April 19, 1995, 49 F.3d 1516 (11th Cir. 1995) 1a

Appendix B - Judgment of the United States Court of Appeals, Eleventh Circuit, Dated April 19, 1995 ..... 5a

Appendix C - Order of the United States District Court, Middle District of Florida, Tampa Division, Dated November 9, 1993 ..... 7a

Appendix D - Judgment of the United States District Court, Middle District of Florida, Tampa Division, Dated November 9, 1993 ..... 9a

Appendix E - Report and Recommendation of United States Magistrate Judge Thomas G. Wilson, United States District Court, Middle District of Florida, Tampa Division, Dated October 13, 1993 ..... 11a

Appendix F - Order of the Provider Reimbursement Review Board Dated October 31, 1990 ..... 18a

Appendix G - *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984) 21a

Appendix H - *Community Hospital of Chandler, Inc. v. Louis W. Sullivan, M.D.*, 963 F.2d 1206 (9th Cir. 1992) 60a

Appendix I - *Episcopal Hospital v. Donna E. Shalala*, 994 F.2d 879 (D.C. Cir. 1993) 81a

Appendix J - *Good Samaritan Hospital, et al., v. Donna E. Shalala, Secretary of Health and Human Services*, 113 S.Ct. 2151 (1993) 94a

Appendix K - *Methodist Hospital v. Shalala*, 6 F.3d 829 (D.C. Cir. 1993) 125a

Appendix L - *Sacred Heart v. Sullivan*, 958 F.2d 537 (3rd Cir. 1992); 958 F.2d 537 (3rd Cir. 1992) 127a

Appendix M - United States Code, Title 42, The Public Health and Welfare, §1395ww(a) 157a

Appendix N - United States Code, Title 42, The Public Health and Welfare, §1395ww(b) 161a

Appendix O - United States Code, Title 42, The Public Health and Welfare, §1395ww(d) 173a

Appendix P -Code of Federal Regulations, Title 42, Public Health, §412.71 ..... 176a

Appendix Q - Code of Federal Regulations, Title 42, Public Health, §412.72 ..... 179a

Appendix R - Senate Report No. 23, 98th Congress, 1st Session 1983 ..... 184a

No. _____

IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

HILLSBOROUGH COUNTY HOSPITAL AUTHORITY, et al.,
Petitioners,

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondent.

Petition for a Writ of Certiorari to the
United States Court of Appeals
for the Eleventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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OPINIONS BELOW

Hillsborough County Hospital Authority, et al. v. Donna E. Shalala, 49 F.3d 1516 (11th Cir. 1995), was entered on April 19, 1995, and is reproduced herein as Appendix A.[1] The opinion and order of the District Court for the Middle District of Florida in *Hillsborough County Hospital Authority, et al. v. Donna E. Shalala*, are unreported and are reproduced herein as Appendices C and D. The decision of the Provider Reimbursement Review Board is unreported and is reproduced herein as Appendix E.

STATEMENT OF JURISDICTION

The opinion of the United States Court of Appeals for the Eleventh Circuit was entered on April 19, 1995, and is reproduced herein as Appendix A.[2]

This Court has jurisdiction to issue the requested writ of certiorari pursuant to 28 U.S.C. §1254(1). Subject matter jurisdiction in the District Court was pursuant to 42 U.S.C. §1395oo(f). The case began as an appeal before the Provider Reimbursement Review Board which, on its own motion, ordered expedited judicial review of the matter pursuant to 42 C.F.R. §405.1842.

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1 The Judgment entered by the Eleventh Circuit Court of Appeals is reproduced herein as Appendix B.

2 Documents in the Appendix are cited as "App."

STATUTES AND REGULATIONS

The following statutes and regulations are set forth in the Appendix to the Petition:

42 U.S.C. §1395ww(a) -	Appendix M
42 U.S.C. §1395ww(b) -	Appendix N
42 U.S.C. §1395ww(d) -	Appendix O
42 C.F.R. §412.71 -	Appendix P
42 C.F.R. §412.72 -	Appendix Q

STATEMENT OF THE CASE

A. Factual Background

This is an appeal brought by 114 acute care hospitals (the "Hospitals") who are Medicare providers, and involves the interpretation of the statutes and regulations that govern reimbursement of the Hospitals and other health care providers under the Medicare Act. Under the Medicare Act, an eligible Medicare beneficiary is entitled to receive certain inpatient and outpatient services from the Hospitals and other healthcare providers which participate in the Medicare Program. A "participating provider" is paid for services rendered to a beneficiary by the Medicare Program through the Secretary of the Department of Health and Human Services (the "Secretary") who is the federal officer responsible for the administration of the Medicare Program. 42 U.S.C. §1395(g). As a practical matter, reimbursement to a participating provider is made through a fiscal intermediary, as an agent of the Medicare program, who audits the provider's cost reports and who follows the regulations promulgated by the Secretary in determining what claims are allowable as part of the provider's reimbursement.

The issue in this case arises from amendments to the Medicare Act in 1982 and 1983 which resulted in confusion over what provisions controlled the reimbursement of Medicare providers during the transition period between the original system of reimbursement and the new system, during which period reimbursement was determined using a blend of the two systems. Specifically, the question before this Court is whether the adjustments for special, unforeseen circumstances mandated under 42 U.S.C. §1395ww(b)(4)(A), which were a part of the original system of reimbursement, are applicable to the calculation of the hospital-specific portion of a hospital's Medicare reimbursement under 42 U.S.C. §1395ww(d) during the four-year transition period under Medicare's prospective payment system. Three courts of appeal, including the court below, have resolved the issue with inconsistent results, using different reasoning and basis. The result is confusion over the state of the law. Specifically, questions of statutory construction have arisen as well as problems with granting judicial deference to agency interpretation which has shifted for no apparent reason except to deny reimbursement to a multitude of Medicare providers.

B. History of the Statute

Until 1982, the Hospitals and other health care providers were reimbursed for the reasonable cost of services actually and necessarily provided to Medicare beneficiaries. 42 U.S.C. §1395x(v). When the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") was enacted, the "reasonable cost" reimbursement scheme was altered with the imposition of a ceiling on the rate of increase of inpatient operating expenses recoverable by a hospital under the Medicare Act. The ceiling was calculated using a provider's "target amount" which, in turn, was defined as follows:

> (i)...[t]he allowable operating costs of inpatient hospital services... recognized under this subchapter for such hospital for the preceding twelve-month cost reporting period...

42 U.S.C. §1395ww(b)(3)(A)(i).

The base year is the 12-month or longer cost reporting period ending on or after September 30, 1982 and before September 30, 1983. Despite the ceiling, TEFRA expressly included a specific exception which allowed a hospital to adjust its calculated "target amount" to account for events or circumstances beyond the hospital's control. In pertinent part, 42 U.S.C. §1395ww(b)(4)(A) (hereinafter "Subsection (b)(4)(A)") (App. N) states as follows:

> The Secretary **shall provide** for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital **where events beyond the hospital's control, or extraordinary circumstances**... create a distortion in the increase in costs for a cost reporting period (including any distortion in the cost of the base period against which such increase is measured). **[emphasis added]**

In 1983, TEFRA was replaced by the Prospective Payment System ("PPS"). PPS radically changed the method of reimbursement for inpatient costs by requiring that the Hospitals and other health care providers be compensated on the basis of prospectively determined national and regional rates, regardless of actual operating costs. 42 U.S.C.

§1395ww(d) (App. O). Because of the dramatic change in the way providers would be reimbursed under PPS, Congress provided a four-year transition period (the "Transition Period") during which Medicare reimbursement was based on a blend of the old and new systems. The express reason for the phase-in period for PPS was to "minimize disruption that might otherwise occur because of sudden changes in reimbursement levels." S.Rep.No. 23, 98th Cong., 1st Sess. 53, *reprinted in* 1983 U.S. Code Cong. & Admin. News 143, 193. (App. R). A hospital's reimbursement for the Transition Period was calculated using a formula combining a hospital-specific component (based on actual allowable costs) of each hospital's payment rate with the PPS federally prescribed reimbursement rate. 42 U.S.C. §1395ww(d)(1)(A). *See also* 42 C.F.R. §412.71 and §412.72 (App. P and App. Q). The hospital-specific portion ("HSP") of a hospital's rate is defined under PPS for the Transition Period as follows:

> [T]he target percentage... of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A) of this subsection)...

42 U.S.C. §1395ww(d)(1)(A)(ii)(I).

The percentage of each rate to be used to calculate reimbursement was statutorily prescribed for each of the four years of the Transition Period, with a gradual increase of basis in the prospective rate. Therefore, during the four years there would be both a TEFRA-based element and a PPS-based element included in every hospital's reimbursement rate. By the fiscal year ending October 1, 1987, inclusion of the actual cost rate in calculating reimbursement would be phased out completely and only the national standardized rate would remain. 42 U.S.C. §1395ww(d)(1)(c).

C. Indigent Health Care Program Assessment

In 1984, subsequent to the Hospitals' base year but prior to the first year for which payments were made under PPS, the State of Florida imposed the Indigent Health Care Program ("IHCP") assessment against all Florida hospitals in order to help fund health care services to indigent persons. The assessment is a recurring annual assessment calculated at one percent (1%) of a hospital's annual net operating revenue for the fiscal year ending subsequent to May 18, 1984, and one and one-half percent (1½%) for each fiscal year thereafter. Fla. Stat. §395.101 (1985); see also Fla. Stat. §409.2662(1) (1985).

Prior to the IHCP, there was no similar assessment or obligation imposed on Florida hospitals to fund indigent care, and these assessments have not been imposed throughout the United States. The IHCP is unique to Florida hospitals. Because the IHCP assessment was imposed subsequent to the Hospitals' base years, the Hospitals' respective target amounts used in the interim years were calculated without factoring in the additional cost of the IHCP assessment. Although the Intermediary determined that the IHCP assessment is an allowable cost (which, as a result, would have had an impact on the Petitioners' base year if it had been in place in 1982), the Intermediary failed to adjust the Petitioners' hospital specific components of their PPS payments to reflect the increased costs to the Hospitals resulting from the IHCP assessment.

D. Proceedings Below

This action began as an appeal to the Provider Reimbursement Review Board (the "PRRB") by 114 Florida acute care hospitals participating in the Medicare Program for a review of the Medicare Intermediary's determination of

the Hospitals' reimbursement for the first fiscal year under PPS. By order dated October 31, 1990, the PRRB, on its own motion, ruled that it did not have the authority to grant the retroactive adjustment to the Hospitals' respective prospective payment rate in order to expedite a judicial review and the Hospitals filed an action in the United States District Court for the Middle District of Florida pursuant to 42 U.S.C. §1395oo(f). On cross motions for summary judgment, the Middle District adopted the Report and Recommendation of United States Magistrate Judge Thomas G. Wilson and entered a judgment in favor of the Secretary.

An appeal was taken to the United States Court of Appeals for the Eleventh Circuit on January 7, 1994, pursuant to Federal Rule of Appellate Procedure 4(a)(1). On April 19, 1995, the Eleventh Circuit affirmed the judgment of the Middle District of Florida by its opinion, which noted conflicts in a prior Circuit Court ruling. [App. A]. This Court has jurisdiction of this matter pursuant to Rule 10, Rules of the Supreme Court of the United States.

REASONS FOR GRANTING THE WRIT

A. To Settle a Controversy Among the Circuits Over a Significant Legal Issue of Continuing Importance

The Petitioners respectfully submit that the issuance of a Writ of Certiorari in this case will allow the Court to settle a conflict among the Third, Ninth, and District of Columbia Circuits, and now the Eleventh Circuit, on the statutory construction of a significant provision of the Social Security Act. The conflicting opinions of the Circuits are based on different and inconsistent legal theories and have

created confusion in the law. Even while relying on the Third Circuit in *Sacred Heart Medical Center v. Sullivan*, 958 F.2d 537 (3rd Cir. 1992) (App. L) and the D.C. Circuit in *Episcopal Hospital et al. v. Shalala*, 994 F.2d 879 (D.C. Cir. 1993) (App. I), the Eleventh Circuit in this case recognized the contrary opinion on the issue espoused by the Ninth Circuit in *Community Hospital of Chandler v. Sullivan*, 963 F.2d 1206 (9th Cir. 1992) (App. H). The confusion of the law, as well as the ongoing litigation in the circuit courts, the district courts and before the PRRB, will continue unless this Court resolves the conflict.

The Petitioners acknowledge that this issue was presented to this Court in the Petition for Certiorari filed in *Episcopal Hospital et al. v. Shalala*, 994 F.2d 879 (D.C. Cir. 1993), *cert. denied*, No. 93-429, 62 U.S.L.W. 3468 (January 18, 1994). However, in that case, the Court of Appeals had found that the Petitioners had failed to qualify as a special exception of Subsection (b)(4)(A), so a decision by this Court that Subsection (b)(4)(A) is applicable under PPS would not have allowed the Petitioners in that case to prevail anyway. In the instant case, the IHCP assessment was determined by the Intermediary to satisfy the accepted standards for the Subsection (b)(4)(A) adjustment and was never contested by the Secretary when the matter was before the PRRB. The Petitioners further acknowledge that this issue was presented to the Court in a Petition for Certiorari filed in *The Methodist Hospital v. Donna E. Shalala*, 6 F.3d 829 (D.C. Cir. 1993), *cert. denied*, No. 93-1449, 114 S.Ct. 2162 (June 6, 1994). In that case, the District of Columbia Circuit overturned the decision of the district court without opinion, relying on its decision in *Episcopal*.

1. Secretary's Interpretation Under the *Chevron* Analysis

Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984) (App. G) provides a two-step process for the review of a challenge to agency action, such as the Secretary's interpretation of the Medicare Act. First, a Court must determine if congressional intent is clear. If so, the analysis is complete and the Secretary must follow the plain meaning of the statute. 467 U.S. at 842. If congressional intent is not clear, a Court must go to the second step and determine if the Secretary's interpretation of the statute is reasonable. If the interpretation is determined to be reasonable, deference should be given to the Secretary. However, as this Court cautioned in *Board of Governors of the Fed. Reserve Sys. v. Dimension Fin. Corp.*, 474 U.S. 361, 368 (1986), "[t]he traditional deference Courts pay to Agency interpretation is not to be applied to alter the clearly expressed intent of Congress."

2. The Error in the Secretary's Interpretation of Subsection (b)(4)(A).

The position the Secretary has taken in this and other cases is that the "special circumstances" exception of Subsection (b)(4)(A) is not applicable to the calculation of the Hospitals' HSP during the Transition Period. This argument is based on the premise that (b)(4)(A) was not expressly incorporated by the language of (b)(3)(A). The Secretary's premise ignores the fact that (b)(3)(A) does not expressly include any subsections, while it does exclude TEFRA provision 42 U.S.C. §1395ww(a). It does not exclude (b)(4)(A). The doctrine of "expressio unius est exclusio alterius" clearly applies in that not being expressly excluded, (b)(4)(A) is included. See also *Andrus v. Glover*

Construction Company, 446 U.S. 608, 617 (1980) ("[w]here Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied in the absence of a contrary legislative intent.").

The Secretary has further argued that Subsection (b)(4)(A) does not apply under PPS because the PPS statute contains its own provision for adjustments and exceptions in Subsection (d)(5), and therefore the provisions in Subsection (b)(4)(A) are at odds with Subsection (d)(5) because Subsection (d)(5) does not repeat (b)(4)(A)'s directive to the Secretary to make adjustments to reimbursement amounts under extraordinary circumstances. The fact that Subsection (d)(5) does not repeat Subsection (b)(4)(A) provides evidence of the congressional intent that Subsection (b)(4)(A) was to be applicable under PPS.

Subsection (d)(5)(I) provides for exceptions to "payment amounts," whereas Subsection (b)(4)(A) provides for exceptions to "such method," referring to the method for determining the HSP of the PPS rate in the first instance. Congress was no doubt aware that Subsection (b)(4)(A) adjustments were one method of ultimately affecting how much a hospital would be paid. It would have been redundant to repeat this provision in Subsection (d)(5). Rather, Congress simply added a number of other exceptions and adjustments in Subsections (b)(5)(A)-(I), each of which covered something other than a cost due to extraordinary circumstances beyond the hospitals' control. The additional exceptions and adjustments in Subsection (d)(5) are a list of situations where Congress felt there should be a change in payment without modifying the underlying and basic determination of the methodology to be used as a starting point for determining the payment amount for all hospitals. Therefore, Petitioners submit that Subsections (b)(4)(A) and (d)(5) should be read in harmony, complementary, giving

effect to each part of the statute in furtherance of a congressional purpose to provide for exceptions both as to methodology as well as to more esoteric payment determinations not predicated on the notion of allowable costs. *See Florida & American Medical Association, Inc. v. Department of Health, Education and Welfare*, 479 F. Supp. 1291. ("Courts have a duty to interpret a statute so that all provisions can be reconciled into a harmonious whole, without internal conflict or repugnancy if possible.").

3. *Chandler*

In *Community Hospital of Chandler v. Sullivan*, 963 F.2d 1206 (9th Cir. 1992), the Ninth Circuit addressed the issue of whether the special exception found in 42 U.S.C. §1395ww(b)(4)(A) is applicable to PPS during the Transition Period. The Court in that case concluded that the TEFRA adjustments under subparagraph (b)(4)(A) are applicable to PPS, utilizing the first prong of the analysis of *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). In its opinion, the *Chandler* Court specifically recognized the contrary ruling in *Sacred Heart Med. Ctr. v. Sullivan*, 958 F.2d 537 (3rd Cir. 1992), and expressly rejected the Third Circuit's reasoning in that case. The Court in *Chandler* noted that under PPS, the starting point for all covered hospitals, was the HSP which in turn required a determination of the hospital's base year costs. However, Subsection (b)(4)(A) was intended to provide the mechanism whereby an aberration or distortion in the base year costs due to extraordinary circumstances would warrant an adjustment to the target amount. There is no other mechanism in the statute to accomplish this result. The Ninth Circuit in *Chandler* thus concluded that Congress intended Subsection (b)(4)(A) to be read in conjunction with Subsection (b)(3)(A) and noted as follows:

> ...[W]e have noted before, "although the PPS is basically embodied within 42 U.S.C. §1395ww(d)... there is clear interface between § 1395ww subsections (b) and (d)." Sunshine Health, 809 F.2d at 1398. In Sunshine Health, we rejected the Secretary's argument that Congress did not intend to incorporate § 1395ww(b)(5). Id. The Secretary has conceded that PPS target amount calculations were based in part on § 1395ww(b)(3)(A). Thus in light of the fact that § 1395ww(d) "by its own terms incorporates one of the main concepts of subsection (b)," we found it illogical to exclude from PPS other subsections of § 1395ww(b). Id. That reasoning applies with equal force here: It would be equally illogical to exclude § 1395ww(b)(4).

963 F.2d at 1214, n.4. It is worth noting that the Secretary did not petition for certiorari from the Ninth Circuit opinion in *Chandler*.

4. *Sacred Heart* and *Episcopal*

The Third and D.C. Circuits, also relying on *Chevron*'s first step analysis, have held that the plain language of the statute evidences clear congressional intent that the TEFRA special exception provision is not applicable to the calculation of the HSP under PPS. The Third Circuit in *Sacred Heart Medical Center v. Sullivan*, rejected the district court's finding that while the TEFRA component was still a part of computing reimbursement during the transition period, it was only reasonable that the corresponding provision which gave TEFRA flexibility should apply. Utilizing a first step *Chevron* analysis, the Third Circuit

further found that deference should be given to the Secretary's "reasonable" interpretation of the statute under a second step analysis of *Chevron*. 958 F.2d 537, 548 (3rd Cir. 1992).

In *Episcopal Hospitals v. Shalala*, the D.C. Circuit also deferred to the Secretary's interpretation of the statute, but without defining the Secretary's interpretation. 994 F.2d 879 (D.C. Cir. 1993). Furthermore, the issue in this case was not an issue in the *Episcopal* case at the district court level. In those proceedings, the parties assumed that the TEFRA adjustments applied in the calculation of the HSP. The question was one of whether the adjustment sought was one which fell under the (b)(4)(A) exception. Not having been an issue at the district court level, a complete legislative and regulatory record was not established on the issue of whether Subsection (b)(4)(A) was applicable under PPS during the transition years. It is also significant to note that the Court in *Episcopal* does not acknowledge the existence of the *Chandler* case nor does it reference the *Sacred Heart* case.

Petitioners submit that the Third and D.C. Circuits erred in ignoring legislative history and congressional intent, and in allowing the Secretary to depart from its prior position without a true "reasoned justification." The deference accorded by the Third Circuit to the Secretary's interpretation is misplaced and inappropriate where the interpretation is inconsistent with prior interpretations and positions taken by the Secretary, and there is no rational reason for the change.

5. District Court Decisions

Until the instant case, every federal district court decision involving this issue has held that the

legislative history of the statute clearly demonstrates congressional intent to incorporate the TEFRA special exception adjustment into PPS during the Transition Period.[3] All of the courts based their conclusion on the clear language of the statute (first prong of the *Chevron* case), obviating the need to make an inquiry into the reasonableness of the Secretary's interpretation. The decision by the district court in this case is forced to depart from the prior decisions because of the *Sacred Heart* and *Episcopal* cases.

6. Question of Continuing Importance

The question presented to the Court in this case is one of continuing importance. Not only are 114 hospitals affected by the Court's decision in this case, but there are five cases involving this issue currently pending before the United States District Court for the District of Columbia Circuit.[4] In addition, there are an unknown number of cases pending before the PRRB.[5]

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[3] *Redbud Hospital District v. Heckler*, Medicare and Medicaid Guide (CCH) ¶34,085 (N.D. Cal. July 30, 1984), *vacated on other grounds*, 473 U.S. 1308 (1985); *Greenville Hospital System v. Heckler*, 642 F. Supp. 15 (D.S.C. 1985), *after remand*, Medicare and Medicaid Guide (CCH) ¶35,880 (D.S.C. 1986); *Newport Hospital and Clinic, Inc. v. Sullivan*, Medicare and Medicaid Guide (CCH) ¶38,844 (D.D.C. Sept. 24, 1990), *Secretary's appeal voluntarily withdrawn* (1991); *The Methodist Hospital v. Sullivan*, Medicare and Medicaid Guide (CCH) ¶39,627 (D.D.C. September 20, 1991), *reversed*, 6 F.3d 829 (D.C. Cir. Sept. 16, 1993) *adopting Episcopal*, 994 F.2d 879 (D.C. Cir. 1993), *cert. denied*, No. 93-1449, 114 S.Ct. 2162 (June 6, 1994); *Sacred Heart Medical Center v. Sullivan*, 1991 U.S. Dist. Lexis 9535 (E.D. Pa. 1991), *reversed*, 958 F.2d 537 (3rd Cir. 1992).

[4] *Nyack Hospital v. Sullivan*, No. 92-0455; *Okeechobee Hospital v. Sullivan*, No. 92-1323; *HCA Services of Texas v. Sullivan*, No. 92-1324; *Hospital Corporation of Tennessee v. Sullivan*, No. 92-1325; and *General Care Corp. v. Sullivan*, No. 92-1326. In addition, there is

B. To Prevent the Propagation of Mistakes and to Clarify the Appropriate Standard of Deference to be Given Agency Interpretations

Standards of deference to agency interpretations of statutes were established in the *Chevron* case and in *Good Samaritan Hospital v. Shalala*, 113 S.Ct. 2151 (1993). Petitioners submit that the Third and District of Columbia Circuits have improperly expanded the standards set forth in *Chevron* and *Good Samaritan* by affording deference to the Secretary's interpretation of Subsection (b)(4)(A) in the *Sacred Heart* and *Episcopal* cases. The District Court and the Eleventh Circuit decisions rendered in this case demonstrate that the errors made by the District of Columbia Circuit in *Episcopal* and by the Third Circuit in *Sacred Heart* are now being propagated.

As stated above, the *Chevron* case provides a two-step analysis for the review of statutory construction. The first step is a determination of whether the intent of Congress is clear, in which case the clear language of the statute should be followed. If congressional intent is not clear, deference will be given to a reasonable interpretation made by a government agency. The *Good Samaritan* case clarified the two-step process by noting the following:

> On the other hand, the consistency of an agency's position is a factor in assessing

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one case pending in the Southern District of New York, *Good Samaritan Hospital Regional Medical Center v. Shalala*, No. 92-8726.

5 The PRRB has no mechanism for determining the number of cases before it involving this issue, although we understand from counsel involved in cases cited herein, that they represent hospitals pending PRRB appeals on this issue.

> the weight that position is due. As we have stated, "[a]n agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held view." ... How much weight should be given to the agency's views in such a situation, and in particular where its shifts might have resulted from intervening in possibly erroneous judicial decisions and its current position from one of our own rulings will depend on the facts of individual cases.

The acknowledgment that blind deference to an agency's interpretation of a statute would be inappropriate is important in this case where the Secretary has taken a position in litigation which is contrary to certain official actions taken with respect to the same TEFRA adjustments.

1. Legislative History.

When TEFRA was enacted, the Congressional Conference Committee Report reflected Congress' intent to maintain fairness in the administration of the Medicare Program and stated as follows:

> The Secretary of HHS would be required to provide for appropriate exemptions, exceptions and adjustments as in the Senate provision. The Conference notes that adjustments could have the effect of either increasing or decreasing the target amount payment amounts. The principal intention in authorizing such adjustments is to take into account factors that would

> distort either base period, or operative cost increase in any of the three years to which the provisions are applicable. Examples of such factors include... extraordinary circumstances beyond the hospital's control...

H.R. Rep. No. 760, 97th Congress, 2d Sess. 420.

When the Secretary adopted regulations implementing PPS, she acknowledged the congressional mandate and stated in the preamble to the final PPS regulations:

> We believe that Congress intended to assure, by giving us broad authority under the law to provide for exceptions, exclusions and adjustments, that some hospitals are not advantaged or disadvantaged by unique circumstances in their base year that do not reflect their usual cost of operation per case. This intent is indicated in §1886(b)(4)(A) [Subsection (b)(4)(A)] of the Act.

49 Fed. Reg. at 261 (January 3, 1984).

2. The Secretary's Changing Position

Hundreds of Medicare providers, including the Petitioners, relied upon the Secretary's assurance that the TEFRA adjustments would be available to calculate the HSP.

Subsequent to the Secretary's statement in the *Federal Register*, the Secretary granted TEFRA adjustments

under Subsection (b)(4)(A) to certain hospitals for PPS purposes, one hospital being Greenville Hospital. *Greenville Hospital Systems v. Heckler*, 642 F. Supp. 15 (D.S.C. 1985) (concerning jurisdiction), *after remand*, Medicare and Medicaid Guide (CCH) ¶35,880 (D.S.C. 1986) (granting retrospective relief for an HSP adjusted by the Secretary under Subsection (b)(4)(A)). In addition, the Secretary conceded in another case in California that Subsection (b)(4)(A) was to be incorporated in determining the target amount used in calculating PPS rates during the transition period. *Redbud Hospital District v. Heckler*, Medicare & Medicaid Guide ¶34,085 (N.D. California 1984).

The Secretary's position in *Sacred Heart* and *Episcopal* is contrary to its initial "official" position and is a *post hoc* rationalization which should be accorded little or no deference at all. *Motor Vehicles Manufacturers Association v. State Farm Mutual Automobile Insurance Company*, 463 U.S. 29 (1983). The Secretary's change in position does not mirror the change allowed in *Good Samaritan* where the agency was found to have adopted a mistaken interpretation of a statute because of an erroneous Court decision. The Secretary has never made that claim with respect to this issue, and has merely changed her position claiming that her prior interpretation was incorrect. Therefore, the deference afforded to the Secretary in the *Episcopal* and *Sacred Heart* cases was clearly incorrect and inconsistent with the standards set forth by this Court in the *Chevron* and *Good Samaritan* cases. The District Court in the instant case, and the Eleventh Circuit's affirmance of that decision, is another example of the flawed reasoning which is inconsistent with the *Chevron* and *Good Samaritan* standards, in ignoring the statement made by the Court in *Good Samaritan* that a lower level of deference should be accorded to changing interpretations.

Petitioners submit that this case would allow this Court the opportunity to clarify its position with respect to the proper judicial deference to be accorded to a new position taken by an agency based on its own conclusion that its initial interpretation was incorrect.

CONCLUSION

Petitioners respectfully request the Court grant this Petition and issue a writ of certiorari to the United States Court of Appeals for the Eleventh Circuit. The granting of the Petitioners' request will allow this Court to address the inconsistency and discrepancy in the law on this critical issue which affects hundreds of Medicare providers.

Respectfully Submitted,

NANCY A. ROMFH
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APPENDIX A --- OPINION OF THE UNITED STATES COURT OF APPEALS, ELEVENTH CIRCUIT, DATED APRIL 19, 1995

HILLSBOROUGH COUNTY HOSPITAL AUTHORITY, d/b/a Tampa General Hospital, et al.,

Plaintiffs-Appellants,

v.

DONNA E. SHALALA, Secretary, United States Department of Health and Human Services,

Defendant-Appellee.

No. 94-2050

April 19, 1995

* * *

James M. McCann, Jr., Mershon, Sawyer, Johnston, Dunwody & Cole, West Palm Beach, FL, for plaintiff.

Lana Smith Sensenig, Department of Health and Human Services, Atlanta, GA, for defendant.

Acute care hospitals sought judicial review of determination by Secretary of Health and Human Services that hospitals were not entitled to adjustment in their Medicare reimbursements based on extraordinary circumstances. The United States District Court for the

Middle District of Florida, No. 91-12-CIV-T-21(B), Ralph W. Nimmons, Jr., J., upheld Secretary's determination. Hospitals appealed. The Court of Appeals held that Medicare's Prospective Payment System (PPS) for reimbursement of health care providers does not incorporate prior provision of the Tax Equity and Fiscal Responsibility Act (TEFRA) which permitted adjustment of reimbursement rates for extraordinary circumstances.

Affirmed.

Social Security and Public Welfare - Key No. 241.10

Medicare's Prospective Payment System (PPS) for reimbursement of health care providers does not incorporate prior provision of the Tax Equity and Fiscal Responsibility Act (TEFRA) directing the Secretary of Health and Human Services to adjust reimbursement amounts where "extraordinary circumstances" create a distortion in the increase in costs for a cost reporting period; the PPS contains its own provision endowing Secretary with authority to create exceptions to amount of reimbursement that would otherwise be afforded under the PPS. Social Security Act, §1886(b)(4)(A), (d), as amended, 42 U.S.C.A. §1395ww(b)(4)(A), (d).

Appeal from the United States District Court for the Middle District of Florida.

Before DUBINA, Circuit Judge, RONEY and ESCHBACH*, Senior Circuit Judges.

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* Honorable Jesse E. Eschbach, Senior U.S. Circuit Judge for the Seventh Circuit, sitting by designation.

PER CURIAM:

Plaintiffs, approximately 114 acute care hospitals ("the Hospitals") belonging to the Florida Hospital Association, appeal the district court's grant of summary judgment in favor of the Secretary of Health and Human Services ("the Secretary") denying the Hospitals' claim that they were entitled to an adjustment in their Medicare reimbursements based on the "extraordinary circumstances" exception of 42 U.S.C. §1395ww(b)(4)(A). Specifically, the district court upheld the Secretary's determination that §1395ww(b)(4)(A) was not incorporated into 42 U.S.C. §1395ww(d), Medicare's Prospective Payment System (PPS). We affirm.

This particular issue of statutory interpretation has already been addressed by three of our sister circuits. Both the D.C. Circuit and the Third Circuit have held that the Secretary could reasonably conclude that Congress did not incorporate the "extraordinary circumstances" exception of §1395ww(b)(4)(A) into the PPS. *Episcopal Hospital v. Shalala*, 994 F.2d 879, 884 (D.C. Cir. 1993), *cert. denied*, ____ U.S. ____, 114 S.Ct. 876, 127 L.Ed.2d 73 (1994); *Sacred Heart Medical Center v. Sullivan*, 958 F.2d 537, 550 (3rd Cir. 1992). In examining the plain language of the PPS statute, these courts point out that §1395ww(d)(1) makes no reference to §1395ww(b)(4)(A), even though it expressly refers to §1395ww(b)(3)(A), and, furthermore, the PPS contains its own list of exceptions in §1395ww(d)(5), eliminating any need to incorporate §1395ww(b)(4)(A)'s exception. *See Episcopal*, 994 F.2d at 883; *Sacred Heart*, 958 F.2d at 545. The *Sacred Heart* court also notes that the legislative history supports the Secretary's determination that Congress did not intend to incorporate §1395ww(b)(4)(A) into the PPS. *Id.*, 958 F.2d at 547. Although the Ninth

Circuit has expressed a contrary view on this issue, *see Community Hospital of Chandler v. Sullivan*, 963 F.2d 1206, 1214 n. 4 (9th Cir. 1992), we nonetheless find the reasoning of the D.C. and Third Circuits persuasive. We therefore AFFIRM the judgment of the district court.

APPENDIX B --- JUDGMENT OF THE UNITED STATES COURT OF APPEALS, ELEVENTH CIRCUIT, DATED APRIL 19, 1995

HILLSBOROUGH COUNTY HOSPITAL AUTHORITY, d/b/a Tampa General Hospital, et al.,

Plaintiffs-Appellants,

v.

DONNA E. SHALALA,

Defendant-Appellee.

No. 94-2050
D.C. Docket No. 91-12-CIV-T-21(B)

April 19, 1995

* * *

James M. McCann, Jr., Mershon, Sawyer, Johnston, Dunwody & Cole, West Palm Beach, FL, for plaintiff.

Lana Smith Sensenig, Department of Health and Human Services, Atlanta, GA, for defendant.

Appeal from the United States District Court
for the Middle District of Florida

Before DUBINA, Circuit Judge, RONEY and ESCHBACH*, Senior Circuit Judges.

JUDGMENT

This cause came to be heard on the transcript of the record from the United States District Court for the Middle District of Florida, and was argued by counsel;

UPON CONSIDERATION WHEREOF, it is now hereby ordered and adjudged by this Court that the judgment of the said District Court in this cause be and the same is hereby AFFIRMED;

It is further ordered that plaintiffs-appellants pay defendant-appellee the costs on appeal to be taxed by the Clerk of this Court.

Entered: April 19, 1995
For the Court: Miguel J. Cortez, Clerk

By: /s/ Matt Davidson
Deputy Clerk

ISSUED AS MANDATE: 6/19/95

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* Honorable Jesse E. Eschbach, Senior U.S. Circuit Judge for the Seventh Circuit, sitting by designation.

APPENDIX C --- ORDER OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION, DATED NOVEMBER 9, 1993.

HILLSBOROUGH COUNTY HOSPITAL AUTHORITY, d/b/a TAMPA GENERAL HOSPITAL, et al.,

Plaintiffs,

v.

DONNA E. SHALALA, Secretary, Department of Health and Human Services.

Defendant.

Case No. 91-12-Civ-T-21B

United States District Court
Middle District of Florida
Tampa Division

November 9, 1993

* * *

James M. McCann, Jr., Mershon, Sawyer, Johnston, Dunwody & Cole, West Palm Beach, FL, for plaintiff.

Lana Smith Sensenig, Department of Health and Human Services, Atlanta, GA, for defendant.

ORDER

This cause came on for consideration of the parties' cross-motions for summary judgment (Dkts. 17 and 26). Pursuant to the Court's Order of referral (Dkt. 35), this matter was considered by the Magistrate Judge, who has filed his report recommending that summary judgment be granted to the defendant.

Upon consideration of the Report and Recommendation (Dkt. 42) of the Magistrate Judge, no objection thereto having been filed, and upon the Court's independent examination of the motions and the file, the Court finds that the Report and Recommendation should be and is hereby **adopted and confirmed** and made a part hereof. Accordingly, it is

ORDERED AND ADJUDGED that the plaintiffs' motion for summary judgment (Dkt. 17) is **DENIED** and the defendant's motion for summary judgment (Dkt. 26) is **GRANTED.** The Clerk is **directed** to enter judgment on behalf of the defendant and against the plaintiffs.

DONE AND ORDERED, at Tampa, Florida, this 9th day of November, 1993.

/s/
RALPH W. NIMMONS, JR.
United States District Judge

Copies to: Counsel of record

APPENDIX D --- JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF FLORIDA, DATED NOVEMBER 9, 1993

HILLSBOROUGH COUNTY HOSPITAL AUTHORITY, d/b/a TAMPA GENERAL HOSPITAL, et al.,

v.

DONNA E. SHALALA, Secretary, Department of Health and Human Services.

Case No. 91-12-Civ-T-21B

United States District Court
Middle District of Florida

November 9, 1993

* * *

James M. McCann, Jr., Mershon, Sawyer, Johnston, Dunwody & Cole, West Palm Beach, FL, for plaintiff.

Lana Smith Sensenig, Department of Health and Human Services, Atlanta, GA, for defendant.

JUDGMENT IN A CIVIL CASE

IT IS ORDERED AND ADJUDGED that plaintiffs' motion for summary judgment is DENIED and the defendant's motion for summary judgment is GRANTED

and judgment is entered on behalf of the defendant and against the plaintiffs.

November 9, 1993
Date

/s/ David L. Edwards
Clerk

/s/ Cheryl E. Krause
Deputy Clerk

APPENDIX E --- REPORT AND RECOMMENDATION OF UNITED STATES MAGISTRATE JUDGE THOMAS G. WILSON, UNITED STATES DISTRICT COURT, MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION, DATED OCTOBER 13, 1993

HILLSBOROUGH COUNTY HOSPITAL AUTHORITY, ET AL.,

Plaintiffs,

v.

DONNA E. SHALALA, Secretary, United States Department of Health and Human Services,

Defendant.

CASE No. 91-12-CIV-T-21(B)

October 13, 1993

* * *

James M. McCann, Jr., Mershon, Sawyer, Johnston, Dunwody & Cole, West Palm Beach, FL, for plaintiff.

Lana Smith Sensenig, Department of Health and Human Services, Atlanta, GA, for defendant.

REPORT AND RECOMMENDATION

This cause came on for a report and recommendation upon the parties' cross motions for summary judgment (Docs. 17 and 26).* At the hearing on the motions, both sides acknowledged that there were no factual disputes that would preclude entry of summary judgment. For the reasons stated below, I recommend that summary judgment be granted in favor of the defendant Secretary of Health and Human Services.

I.

This matter concerns the interpretation of statutes that govern reimbursement of hospitals and other health care providers under the Social Security Act. The Social Security Act was amended several times during the 1980's with the result that, in the circumstances presented here, the relationship between the amendments left the controlling law unclear. Accordingly, it is appropriate to outline those various amendments in order to explain the dispute in this case.

Until 1982, hospitals and other health care providers were reimbursed for the costs of services actually and necessarily provided to Medicare beneficiaries under the Social Security Act. 42 U.S.C. 1395x(v). In 1982, however, Congress enacted the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), which altered the "reasonable cost" reimbursement scheme by imposing a ceiling on the rate of increase of inpatient operating expenses recoverable under

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* This matter was specifically referred to the undersigned by the Honorable Ralph W. Nimmons, Jr., United States District Judge (Doc. 35).

the Social Security Act. This rate-of-increase ceiling was calculated using a hospital's "target amount," a statutorily defined amount which, in turn, was based on the hospital's actual operating costs for a particular twelve-month cost reporting period. 42 U.S.C. 1395ww(b)(3)(A). Significantly, the TEFRA plan included a specific exception permitting hospitals to adjust their calculated "target amount" to account for "events beyond the hospital's control or extraordinary circumstances" which rendered the "base year" operating-cost estimate inaccurate. 42 U.S.C. 1395ww(b)(4)(A).

In 1983, however, Congress replaced the TEFRA reimbursement scheme with the Prospective Payment System ("PPS") that is currently in effect today. This reform of the Medicare Program substantially changed the method of reimbursement for inpatient costs, since it requires that hospitals and other health care providers be compensated on the basis of prospectively determined national and regional rates, rather than actual operating costs. Because the PPS represented such a dramatic change in the calculation of inpatient cost reimbursement, Congress provided a four (4) year transition period to enable hospitals and other health care providers to adjust their operating procedures. During this interim period, Medicare reimbursement for inpatient hospital services was based upon statutorily prescribed percentages of both the hospital's actual costs and the PPS's federally prescribed reimbursement rate. The dispute in this case involves the method of computation of a hospital's "target amount" that is used in this interim period. 42 U.S.C. 1395ww(b)(3)(A).

The plaintiffs, approximately 114 acute care hospitals in the State of Florida, each seek to amend the imputed operating costs used in the calculation of their respective "target amounts" to reflect the increase in operating costs

precipitated by the Indigent Health Care Program ("IHCP") assessment imposed in 1984 by the State of Florida. The plaintiffs argue that each hospital's "target amount" under 42 U.S.C. 1395ww(b)(3)(A) was calculated without respect to these IHCP assessments, and that 42 U.S.C. 1395ww(b)(4)(A), which permits an adjustment for "extraordinary circumstances," entitles them to include the IHCP assessments into the calculation (Doc. 39). Such an adjustment would permit the plaintiff hospitals to increase their §1395ww(b)(3)(A) "target amount," which would in turn result in a greater recovery during the interim period. The Secretary, in contrast, contends that §1395ww(b)(4)(A), which is a remnant from TEFRA, has no application to the calculation of the "target amount" during the interim period.

II.

The PPS provisions refer in 42 U.S.C. 1395ww(d)(1)(A) to §1395ww(b)(3)(A) for the definition of a hospital's "target amount," the amount used in calculating a hospital's operating costs for a twelve-month cost reporting period. Because §1395ww(b)(3)(A) was an operative provision under the prior TEFRA reimbursement scheme, the plaintiffs argue that the interim scheme also must have incorporated from TEFRA §1395ww(b)(4)(A), which authorized adjustments to the "target amount" for extraordinary circumstances.

The plaintiffs' argument, however, is not supported by the language of the PPS provisions. Those provisions, importantly, make absolutely no reference to §1395ww(b)(4)(A). Moreover, §1395ww(b)(3)(A), which the PPS expressly incorporates, enumerates only subparagraphs C, D, and E as exceptions from the (b)(3)(A) definition of a hospital's "target amount." In other words,

neither the PPS provisions, nor the statutorily incorporated definition of "target amount" adopts the §1395ww(b)(4)(A) "extraordinary circumstances" exception.

Furthermore, the statutory scheme indicates that Congress did not intend to incorporate §1395ww(b)(4)(A) into the PPS. Thus, the adoption of §1395ww(b)(3)(A)'s definition of "target amount" shows that Congress considered the incorporation of TEFRA provisions and apparently elected not to incorporate §1395ww(b)(4)(A). This conclusion is strengthened by the fact that the PPS itself contains its own list of exceptions and adjustments. 42 U.S.C. 1395ww(d)(5)(A-I).

For these reasons, the Secretary's position that the PPS does not include §1395ww(b)(4)(A) is clearly the better reading of the statutory scheme. The issue, however, is not whether the Secretary's construction of the statute is the preferred interpretation, but simply whether it is a reasonable one. In *Good Samaritan Hospital v. Shalala*, ___ U.S. ___, 61 U.S.L.W. 4554, 4557 (1993), the Supreme Court recently reiterated that, in the case of a statutory ambiguity, the courts will generally defer to a permissible interpretation espoused by the agency entrusted with the statute's implementation.

The deference afforded the Secretary's interpretation is not lost because the Secretary previously had a different view of the relationship between §1395ww(b)(3)(A) and §1395ww(b)(4)(A). As the Supreme Court observed in *Good Samaritan Hospital*, "the Secretary is not estopped from changing a view she believes to have been grounded upon a mistaken legal interpretation." Id. at 4558. Here, counsel for the Secretary noted during the hearing that the Secretary's initial confusion regarding the interaction between these two provisions is at least partly attributable to the difficulties associated with the dramatic change in

approach in the statutory schemes. It was undoubtedly also partly attributable to the prolixity and obfuscation for which Social Security statutes are legendary.

As previously indicated, the Secretary's conclusion that §1395ww(b)(4)(A) is not a part of the interim reimbursement scheme is the better interpretation of the pertinent statutory provisions. In all events, her reading of those provisions is certainly at least as plausible as the plaintiffs' construction. Id. at 4558-4559. Accordingly, her interpretation should be accepted.

III.

Three courts of appeals have recently addressed this particular issue of statutory construction. The courts of appeals for both the Third Circuit and the District of Columbia Circuit have considered whether §1395ww(b)(4)(A) should be imported into the calculation of a hospital's "target amount" under §1395ww(b)(3)(A). After full analysis, each of those Circuits concluded that it should not. *Sacred Heart Medical Center v. Sullivan*, 958 F.2d 537 (3d Cir. 1992); *Episcopal Hospital v. Shalala*, ___ F.2d ___ [Nos. 92-5033 and 92-5034, D.C. Cir. June 18, 1993] (Doc. 39, Ex.).

The Ninth Circuit Court of Appeals in *Community Hospital of Chandler v. Sullivan*, 963 F.2d 1206 (9th Cir. 1992), indicated a contrary conclusion. That decision, however, failed to address certain critical points. For example, the Ninth Circuit failed to explain why the Secretary's statutory interpretation should not be accorded deference. In addition, the Court did not consider the impact of the PPS's own exceptions and adjustments in §1395ww(d)(5). As a result, the Ninth Circuit's decision is not sufficiently persuasive to warrant disregarding the well

reasoned opinions of both the Third Circuit and the District of Columbia Circuit.

IV.

For all of the foregoing reasons, I recommend that summary judgment be granted in favor of the Secretary.

Respectfully submitted,

/s/
THOMAS G. WILSON
United States Magistrate Judge

NOTICE TO PARTIES

Failure to file written objections to the proposed findings and recommendations contained in this report within ten days from the date of its service shall bar an aggrieved party from attacking the factual findings on appeal. 28 U.S.C. 636(b)(1).

APPENDIX F --- ORDER OF THE PROVIDER REIMBURSEMENT REVIEW BOARD DATED OCTOBER 31, 1990

Case No.: TM:86-1539G
90-D61

CERTIFIED MAIL

Joanne Erde, Esq.
Mershon, Sawyer, Johnston, Dunwody & Cole
Southeast Financial Center
200 S. Biscayne Blvd., Suite 4500

Dear Ms. Erde:

RE: Florida Hospital Specific Rate Group Appeal, Provider Nos. - Various, Case No. 86-1539G, 90-D61, FYE - First PPS year, Board's Own Motion Determination That It Lacks Authority To Decide Whether the PPS Hospital Specific Rate (HSR) Should Be Adjusted to Reflect a Factor for the Indigent Care Tax Assessment

This is in response to the Provider's request for appeal of the Indigent Care Tax Assessment issue in the above-captioned case. Pursuant to 42 CFR 405.1842, the Board, on its Own Motion, has decided to grant expedited judicial review on the issue of whether the PPS Hospital Specific Rate (HSR) in the first PPS year should be adjusted to reflect a factor for the Indigent Care Tax Assessment, pursuant to 42 CFR 412.70 et seq. The above-cited regulatory provision permits a provider, which has requested and is entitled to a hearing before the Board, under 42 USC 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an

issue involving a question of law or regulation where the Board determines that it is without authority to decide such question.

The Board has reviewed the Providers' submissions pertaining to the requests for hearing. The documentation shows that the estimated amount in controversy exceeds $50,000.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject year and that the Providers are entitled to a hearing before the Board;

2. That there are no findings of fact for resolution before the Board;

3. That the Board is bound by the applicable existing Medicare law and regulations (42 CFR 405.1867); and

4. That the Board is without authority to decide the legal question of whether the PPS Hospital Specific Rate in the first PPS year should be adjusted to reflect a factor for the Indigent Care Tax Assessment, pursuant to 42 CFR 412.70 et seq.

Accordingly, the Board finds that this case properly falls within the provisions of 42 USC 1395oo(f)(1) and hereby grants expedited judicial review on its Own Motion for the Hospital Specific Rate issue for the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

Arthur P. Owens
Keith E. Braganza
Sally A. Kirkpatrick
Joseph F. Sloan

/s/
Joseph F. Sloan
Board Member

Enclosures
Section 1878(f)(1) of the Social Security Act, as amended

cc: Elaine C. Powell, Blue Cross of Florida
Terry Hamaker, Mutual of Omaha
William Braggs, BCBSA

APPENDIX G

CHEVRON, U.S.A., INC., Petitioner,

v.

NATURAL RESOURCES DEFENSE
COUNCIL, INC., et al.
AMERICAN IRON AND STEEL INSTITUTE, et al.,

Petitioners,

v.

NATURAL RESOURCES DEFENSE
COUNCIL, INC., et al.
William D. RUCKELSHAUS, Administrator,
Environmental Protection Agency,

Petitioner,

v.

NATURAL RESOURCES DEFENSE
COUNCIL, INC., et al.

Nos. 82-1005, 82-1247 and 82-1591.

Supreme Court of the United States

Argued Feb. 29, 1984.
Decided June 25, 1984.
Rehearing Denied Aug. 16, 1984.
See 468 U.S. 1227, 105 S.Ct. 28, 29.

Petition was filed for review of order of the Environmental Protection Agency. The Court of Appeals, 685 F.2d 718, vacated regulations, and certiorari was granted. The Supreme Court, Justice Stevens, held that Environmental Protection Agency regulation allowing states to treat all pollution-emitting devices within same industrial grouping as though they were encased within single "bubble" was based on permissible construction of term "stationary source" in Clean Air Act Amendments.
Reversed.

[1] FEDERAL COURTS k445
170Bk445
Supreme Court reviews judgments, not opinions.

[2] STATUTES k219(2)
361k219(2)
When court reviews agency's construction of statute which it administers, court is confronted with two questions: whether Congress has directly spoken on precise question at issue; if statute is silent or ambiguous with respect to specific issue, question for court is whether agency's answer is based on permissible construction of statute.

[2] STATUTES k219(4)
361k219(4)
When court reviews agency's construction of statute which it administers, court is confronted with two questions: whether Congress has directly spoken on precise question at issue; if statute is silent or ambiguous with respect to specific issue, question for court is whether agency's answer is based on permissible construction of statute.

[3] STATUTES k219(4)
361k219(4)
Judiciary is final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent.

[4] STATUTES k219(1)
361k219(1)
Court need not conclude that agency's construction of statute which it administered was only one it permissibly could have adopted to uphold construction, or even reading the court would have reached if question initially had arisen in judicial proceeding.

[5] STATUTES k219(1)
361k219(1)
Where legislative delegation to agency on particular question is implicit rather than explicit, court may not substitute its own construction of statutory provision for reasonable interpretation made by administrator of agency.

[6] STATUTES k219(1)
361k219(1)
Considerable weight should be accorded to executive department's construction of statutory scheme it is entrusted to administer.

[7] HEALTH AND ENVIRONMENT k25.6(3.1)
199k25.6(3.1)
Formerly 199k25.6(3)
Environmental Protection Agency regulation allowing states to treat all pollution-emitting devices within same industrial grouping as though they were encased within single "bubble" was based on permissible construction of term "stationary source" in Clean Air Act Amendments. Clean Air Act, ss

111(a)(3), 172(b)(6), 302(j), as amended, 42 U.S.C.A. ss 7411(a)(3), 7502(b)(6), 7602(j).
Syllabus [FNa1]

FNa1. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Lumber Co.*, 200 U.S. 321, 337, 26 S.Ct. 282, 287, 50 L.Ed. 499.

The Clean Air Act Amendments of 1977 impose certain requirements on States that have not achieved the national air quality standards established by the Environmental Protection Agency (EPA) pursuant to earlier legislation, including the requirement that such "nonattainment" States establish a permit program regulating "new or modified major stationary sources" of air pollution. Generally, a permit may not be issued for such sources unless stringent conditions are met. EPA regulations promulgated in 1981 to implement the permit requirement allow a State to adopt a plantwide definition of the term "stationary source," under which an existing plant that contains several pollution-emitting devices may install or modify one piece of equipment without meeting the permit conditions if the alteration will not increase the total emissions from the plant, thus allowing a State to treat all of the pollution- emitting devices within the same industrial grouping as though they were encased within a single "bubble." Respondents filed a petition for review in the Court of Appeals, which set aside the regulations embodying the "bubble concept" as contrary to law. Although recognizing that the amended Clean Air Act does not explicitly define what Congress envisioned as a "stationary source" to which the permit program should apply, and that the issue was not squarely addressed in the legislative history, the court concluded that, in view of the purpose of the nonattainment program to improve rather than

merely maintain air quality, a plantwide definition was "inappropriate," while stating it was mandatory in programs designed to maintain existing air quality.

Held: The EPA's plantwide definition is a permissible construction of the statutory term "stationary source." Pp. 2781-2793.

(a) With regard to judicial review of an agency's construction of the statute which it administers, if Congress has not directly spoken to the precise question at issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute. Pp. 2781-2783.

(b) Examination of the legislation and its history supports the Court of Appeals' conclusion that Congress did not have a specific intention as to the applicability of the "bubble concept" in these cases. Pp. 2783-2786.

(c) The legislative history of the portion of the 1977 Amendments dealing with nonattainment areas plainly discloses that in the permit program Congress sought to accommodate the conflict between the economic interest in permitting capital improvements to continue and the environmental interest in improving air quality. Pp. 2786-2787.

(d) Prior to the 1977 Amendments, the EPA had used a plantwide definition of the term "source," but in 1980 the EPA ultimately adopted a regulation that, in essence, applied the basic reasoning of the Court of Appeals here, precluding use of the "bubble concept" in nonattainment States' programs designed to enhance air quality. However, when a new administration took office 1981, the EPA, in promulgating the regulations involved here, reevaluated the various arguments that had been advanced in connection

with the proper definition of the term "source" and concluded that the term should be given the plantwide definition in nonattainment areas. Pp. 2787-2790.

(e) Parsing the general terms in the text of the amended Clean Air Act-- particularly the provisions of ss 302(j) and 111(a)(3) pertaining to the definition of "source"--does not reveal any actual intent of Congress as to the issue in these cases. To the extent any congressional "intent" can be discerned from the statutory language, it would appear that the listing of overlapping, illustrative terms was intended to enlarge, rather than to confine, the scope of the EPA's power to regulate particular sources in order to effectuate the policies of the Clean Air Act. Similarly, the legislative history is consistent with the view that the EPA should have broad discretion in implementing the policies of the 1977 Amendments. The plantwide definition is fully consistent with the policy of allowing reasonable economic growth, and the EPA has advanced a reasonable explanation for its conclusion that the regulations serve environmental objectives as well. The fact that the EPA has from time to time changed its interpretation of the term "source" does not lead to the conclusion that no deference should be accorded the EPA's interpretation of the statute. An agency, to engage in informed rulemaking, must consider varying interpretations and the wisdom of its policy on a continuing basis. Policy arguments concerning the "bubble concept" should be addressed to legislators or administrators, not to judges. The EPA's interpretation of the statute here represents a reasonable accommodation of manifestly competing interests and is entitled to deference. Pp. 2790-2793.

222 U.S.App.D.C. 268, 685 F.2d 718 (1982), reversed.
Paul M. Bator, Cambridge, Mass., for petitioners.
David D. Doniger, Washington, D.C., for respondents.

Justice STEVENS delivered the opinion of the Court.

In the Clean Air Act Amendments of 1977, Pub.L. 95-95, 91 Stat. 685, Congress enacted certain requirements applicable to States that had not achieved the national air quality standards established by the Environmental Protection Agency (EPA) pursuant to earlier legislation. The amended Clean Air Act required these "nonattainment" States to establish a permit program regulating "new or modified major stationary sources" of air pollution. Generally, a permit may not be issued for a new or modified major stationary source unless several stringent conditions are met. [FN1] The EPA regulation promulgated to implement this permit requirement allows a State to adopt a plantwide definition of the term "stationary source." [FN2] Under this definition, an existing plant that contains several pollution-emitting devices may install or modify one piece of equipment without meeting the permit conditions if the alteration will not increase the total emissions from the plant. The question presented by these cases is whether EPA's decision to allow States to treat all of the pollution-emitting devices within the same industrial grouping as though they were encased within a single "bubble" is based on a reasonable construction of the statutory term "stationary source."

FN1. Section 172(b)(6), 42 U.S.C. §7502(b)(6), provides: "The plan provisions required by subsection (a) shall-- ..... "(6) require permits for the construction and operation of new or modified major stationary sources in accordance with section 173 (relating to permit requirements)." 91 Stat. 747.

FN2. "(i) 'Stationary source' means any building, structure, facility, or installation which emits or may emit any air pollutant subject to regulation under the Act. "(ii) 'Building,

structure, facility, or installation' means all of the pollutant-emitting activities which belong to the same industrial grouping, are located on one or more contiguous or adjacent properties, and are under the control of the same person (or persons under common control) except the activities of any vessel." 40 C.F.R. ss 51.18(j)(1)(i) and (ii) (1983).

I.

The EPA regulations containing the plantwide definition of the term stationary source were promulgated on October 14, 1981. 46 Fed.Reg. 50766. Respondents [FN3] filed a timely petition for review in the United States Court of Appeals for the District of Columbia Circuit pursuant to 42 U.S.C. §7607(b)(1). [FN4] The Court of Appeals set aside the regulations. *National Resources Defense Council, Inc. v. Gorsuch*, 222 U.S.App.D.C. 268, 685 F.2d 718 (1982).

FN3. National Resources Defense Council, Inc., Citizens for a Better Environment, Inc., and North Western Ohio Lung Association, Inc.

FN4. Petitioners, Chevron U.S.A. Inc., American Iron and Steel Institute, American Petroleum Institute, Chemical Manufacturers Association, Inc., General Motors Corp., and Rubber Manufacturers Association were granted leave to intervene and argue in support of the regulation.

The court observed that the relevant part of the amended Clean Air Act "does not explicitly define what Congress envisioned as a 'stationary source, to which the permit program ... should apply," and further stated that the precise issue was not "squarely addressed in the legislative history." Id., at 273, 685 F.2d, at 723. In light of its conclusion that the legislative history bearing on the question was "at best contradictory," it reasoned that "the purposes of the

nonattainment program should guide our decision here." Id., at 276, n. 39, 685 F.2d, at 726, n. 39. [FN5] Based on two of its precedents concerning the applicability of the bubble concept to certain Clean Air Act programs, [FN6] the court stated that the bubble concept was "mandatory" in programs designed merely to maintain existing air quality, but held that it was "inappropriate" in programs enacted to improve air quality. Id., at 276, 685 F.2d, at 726. Since the purpose of the permit program--its "raison d'etre," in the court's view--was to improve air quality, the court held that the bubble concept was inapplicable in these cases under its prior precedents. Ibid. It therefore set aside the regulations embodying the bubble concept as contrary to law. We granted certiorari to review that judgment, 461 U.S. 956, 103 S.Ct. 2427, 77 L.Ed.2d 1314 (1983), and we now reverse.

FN5. The court remarked in this regard: "We regret, of course, that Congress did not advert specifically to the bubble concept's application to various Clean Air Act programs, and note that a further clarifying statutory directive would facilitate the work of the agency and of the court in their endeavors to serve the legislators' will." 222 U.S.App.D.C., at 276, n. 39, 685 F.2d, at 726, n. 39.

FN6. Alabama Power Co. v. Costle, 204 U.S.App.D.C. 51, 636 F.2d 323 (1979); *ASARCO Inc. v. EPA*, 188 U.S.App.D.C. 77, 578 F.2d 319 (1978).

[1] The basic legal error of the Court of Appeals was to adopt a static judicial definition of the term "stationary source" when it had decided that Congress itself had not commanded that definition. Respondents do not defend the legal reasoning of the Court of Appeals. [FN7] Nevertheless, since this Court reviews judgments, not opinions, [FN8] we must determine whether the Court of Appeals' legal error

resulted in an erroneous judgment on the validity of the regulations.

FN7. Respondents argued below that EPA's plantwide definition of "stationary source" is contrary to the terms, legislative history, and purposes of the amended Clean Air Act. The court below rejected respondents' arguments based on the language and legislative history of the Act. It did agree with respondents contention that the regulations were inconsistent with the purposes of the Act, but did not adopt the construction of the statute advanced by respondents here. Respondents rely on the arguments rejected by the Court of Appeals in support of the judgment, and may rely on any ground that finds support in the record. See *Ryerson v. United States*, 312 U.S. 405, 408, 61 S.Ct. 656, 658, 85 L.Ed. 917 (1941); *LeTulle v. Scofield*, 308 U.S. 415, 421, 60 S.Ct. 313, 316, 84 L.Ed. 355 (1940); *Langnes v. Green*, 282 U.S. 531, 533-539, 51 S.Ct. 243, 244-246, 75 L.Ed. 520 (1931).

FN8. e.g., *Black v. Cutter Laboratories*, 351 U.S. 292, 297, 76 S.Ct. 824, 827, 100 L.Ed. 1188 (1956); *J.E. Riley Investment Co. v. Commissioner*, 311 U.S. 55, 59, 61 S.Ct. 95, 97, 85 L.Ed. 36 (1940); *Williams v. Norris*, 12 Wheat. 117, 120, 6 L.Ed. 571 (1827); *McClung v. Silliman*, 6 Wheat. 598, 603, 5 L.Ed. 340 (1821).

II.

[2][3][4] When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. [FN9] If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, [FN10] as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute. [FN11]

FN9. The judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent. See, e.g., *FEC v. Democratic Senatorial Campaign Committee*, 454 U.S. 27, 32, 102 S.Ct. 38, 42, 70 L.Ed.2d 23 (1981); *SEC v. Sloan*, 436 U.S. 103, 117-118, 98 S.Ct. 1702, 1711-1712, 56 L.Ed.2d 148 (1978); *FMC v. Seatrain Lines, Inc.*, 411 U.S. 726, 745-746, 93 S.Ct. 1773, 1784-1785, 36 L.Ed.2d 620 (1973); *Volkswagenwerk v. FMC*, 390 U.S. 261, 272, 88 S.Ct. 929, 935, 19 L.Ed.2d 1090 (1968); *NLRB v. Brown*, 380 U.S. 278, 291, 85 S.Ct. 980, 988, 13 L.Ed.2d 839 (1965); *FTC v. Colgate-Palmolive Co.*, 380 U.S. 374, 385, 85 S.Ct. 1035, 1042, 13 L.Ed.2d 904 (1965); *Social Security Board v. Nierotko*, 327 U.S. 358, 369, 66 S.Ct. 637, 643, 90 L.Ed. 718 (1946); *Burnet v. Chicago Portrait Co.*, 285 U.S. 1, 16, 52 S.Ct. 275, 281, 76 L.Ed. 587 (1932); *Webster v. Luther*, 163 U.S. 331, 342, 16 S.Ct. 963, 967, 41 L.Ed. 179 (1896). If a court, employing traditional tools of

statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect.

FN10. See generally, R. Pound, The Spirit of the Common Law 174-175 (1921).

FN11. The court need not conclude that the agency construction was the only one it permissibly could have adopted to uphold the construction, or even the reading the court would have reached if the question initially had arisen in a judicial proceeding. *FEC v. Democratic Senatorial Campaign Committee*, 454 U.S., at 39, 102 S.Ct., at 46; *Zenith Radio Corp. v. United States*, 437 U.S. 443, 450, 98 S.Ct. 2441, 2445, 57 L.Ed.2d 337 (1978); *Train v. Natural Resources Defense Council, Inc.*, 421 U.S. 60, 75, 95 S.Ct. 1470, 1479, 43 L.Ed.2d 731 (1975); *Udall v. Tallman*, 380 U.S. 1, 16, 85 S.Ct. 792, 801, 13 L.Ed.2d 616 (1965); *Unemployment Compensation Comm'n v. Aragon*, 329 U.S. 143, 153, 67 S.Ct. 245, 250, 91 L.Ed. 136 (1946); *McLaren v. Fleischer*, 256 U.S. 477, 480-481, 41 S.Ct. 577, 577-578, 65 L.Ed. 1052 (1921).

[5] "The power of an administrative agency to administer a congressionally created ... program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress." *Morton v. Ruiz*, 415 U.S. 199, 231, 94 S.Ct. 1055, 1072, 39 L.Ed.2d 270 (1974). If Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation. Such legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute. [FN12] Sometimes the legislative delegation to an agency on a particular question is implicit rather than explicit. In such a case, a court may not substitute its own

construction of a statutory provision for a reasonable interpretation made by the administrator of an agency. [FN13]

FN12. See, e.g., *United States v. Morton*, 467 U.S. 822, 834, 104 S.Ct. 2769, 2776, 81 L.Ed.2d 680 (1984) *Schweiker v. Gray Panthers*, 453 U.S. 34, 44, 101 S.Ct. 2633, 2640, 69 L.Ed.2d 460 (1981); *Batterton v. Francis*, 432 U.S. 416, 424-426, 97 S.Ct. 2399, 2404-2406, 53 L.Ed.2d 448 (1977); *American Telephone & Telegraph Co. v. United States*, 299 U.S. 232, 235- 237, 57 S.Ct. 170, 172-173, 81 L.Ed. 142 (1936).

FN13. e.g., *INS v. Jong Ha Wang*, 450 U.S. 139, 144, 101 S.Ct. 1027, 1031, 67 L.Ed.2d 123 (1981); *Train v. Natural Resources Defense Council, Inc.*, 421 U.S., at 87, 95 S.Ct., at 1485.

[6] We have long recognized that considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer, [FN14] and the principle of deference to administrative interpretations.

FN14. *Aluminum Co. of America v. Central Lincoln Peoples' Util. Dist.*, 467 U.S. 380, 389, 104 S.Ct. 2472, 2479-2480, 81 L.Ed.2d 301 (1984); *Blum v. Bacon*, 457 U.S. 132, 141, 102 S.Ct. 2355, 2361, 72 L.Ed.2d 728 (1982); *Union Electric Co. v. EPA*, 427 U.S. 246, 256, 96 S.Ct. 2518, 2525, 49 L.Ed.2d 474 (1976); *Investment Company Institute v. Camp*, 401 U.S. 617, 626-627, 91 S.Ct. 1091, 1097, 28 L.Ed.2d 367 (1971); *Unemployment Compensation Comm'n v. Aragon*, 329 U.S., at 153-154, 67 S.Ct., at 250-251; *NLRB v. Hearst Publications, Inc.*, 322 U.S. 111, 131, 64 S.Ct. 851, 860, 88 L.Ed. 1170 (1944); *McLaren v. Fleischer*, 256 U.S., at 480-481, 41 S.Ct., at 577-578; *Webster v. Luther*, 163 U.S., at 342, 16 S.Ct., at 967; *Brown*

v. United States, 113 U.S. 568, 570-571, 5 S.Ct. 648, 649-650, 28 L.Ed. 1079 (1885); *United States v. Moore*, 95 U.S. 760, 763, 24 L.Ed. 588 (1878); *Edwards' Lessee v. Darby*, 12 Wheat. 206, 210, 6 L.Ed. 603 (1827).

"has been consistently followed by this Court whenever decision as to the meaning or reach of a statute has involved reconciling conflicting policies, and a full understanding of the force of the statutory policy in the given situation has depended upon more than ordinary knowledge respecting the matters subjected to agency regulations. See, e.g., *National Broadcasting Co. v. United States*, 319 U.S. 190 [63 S.Ct. 997, 87 L.Ed. 1344]; *Labor Board v. Hearst Publications, Inc.*, 322 U.S. 111 [64 S.Ct. 851, 88 L.Ed. 1170]; *Republic Aviation Corp. v. Labor Board*, 324 U.S. 793 [65 S.Ct. 982, 89 L.Ed. 1372]; *Securities & Exchange Comm'n v. Chenery Corp.*, [332] 322 U.S. 194 [67 S.Ct. 1575, 91 L.Ed. 1995]; *Labor Board v. Seven-Up Bottling Co.*, 344 U.S. 344 [73 S.Ct. 287, 97 L.Ed. 377]. "... If this choice represents a reasonable accommodation of conflicting policies that were committed to the agency's care by the statute, we should not disturb it unless it appears from the statute or its legislative history that the accommodation is not one that Congress would have sanctioned." *United States v. Shimer*, 367 U.S. 374, 382, 383, 81 S.Ct. 1554, 1560, 1561, 6 L.Ed.2d 908 (1961). *Accord Capital Cities Cable, Inc. v. Crisp*, 467 U.S. 691, 699-700, 104 S.Ct. 2694, 2700-2701, 81 L.Ed.2d 580 (1984).

In light of these well-settled principles it is clear that the Court of Appeals misconceived the nature of its role in reviewing the regulations at issue. Once it determined, after its own examination of the legislation, that Congress did not actually have an intent regarding the applicability of the bubble concept to the permit program, the question before it was not whether in its view the concept is "inappropriate" in

the general context of a program designed to improve air quality, but whether the Administrator's view that it is appropriate in the context of this particular program is a reasonable one. Based on the examination of the legislation and its history which follows, we agree with the Court of Appeals that Congress did not have a specific intention on the applicability of the bubble concept in these cases, and conclude that the EPA's use of that concept here is a reasonable policy choice for the agency to make.

III.

In the 1950's and the 1960's Congress enacted a series of statutes designed to encourage and to assist the States in curtailing air pollution. See generally *Train v. Natural Resources Defense Council, Inc.*, 421 U.S. 60, 63-64, 95 S.Ct. 1470, 1474-1475, 43 L.Ed.2d 731 (1975). The Clean Air Amendments of 1970, Pub.L. 91-604, 84 Stat. 1676, "sharply increased federal authority and responsibility in the continuing effort to combat air pollution," 421 U.S., at 64, 95 S.Ct., at 1474, but continued to assign "primary responsibility for assuring air quality" to the several States, 84 Stat. 1678. Section 109 of the 1970 Amendments directed the EPA to promulgate National Ambient Air Quality Standards (NAAQS's) [FN15] and §110 directed the States to develop plans (SIP's) to implement the standards within specified deadlines. In addition, §111 provided that major new sources of pollution would be required to conform to technology-based performance standards; the EPA was directed to publish a list of categories of sources of pollution and to establish new source performance standards (NSPS) for each. Section 111(e) prohibited the operation of any new source in violation of a performance standard.

FN15. Primary standards were defined as those whose attainment and maintenance were necessary to protect the

public health, and secondary standards were intended to specify a level of air quality that would protect the public welfare.

Section 111(a) defined the terms that are to be used in setting and enforcing standards of performance for new stationary sources. It provided: "For purposes of this section: ..... "(3) The term 'stationary source' means any building, structure, facility, or installation which emits or may emit any air pollutant." 84 Stat. 1683. In the 1970 Amendments that definition was not only applicable to the NSPS program required by s 111, but also was made applicable to a requirement of §110 that each state implementation plan contain a procedure for reviewing the location of any proposed new source and preventing its construction if it would preclude the attainment or maintenance of national air quality standards. [FN16]

FN16. See §§110(a)(2)(D) and 110(a)(4).

In due course, the EPA promulgated NAAQS's, approved SIP's, and adopted detailed regulations governing NSPS's for various categories of equipment. In one of its programs, the EPA used a plantwide definition of the term "stationary source." In 1974, it issued NSPS's for the nonferrous smelting industry that provided that the standards would not apply to the modification of major smelting units if their increased emissions were offset by reductions in other portions of the same plant. [FN17]

FN17. The Court of Appeals ultimately held that this plantwide approach was prohibited by the 1970 Act, see ASARCO Inc., 188 U.S.App.D.C., at 83-84, 578 F.2d, at 325-327. This decision was rendered after enactment of the 1977 Amendments, and hence the standard was in effect when Congress enacted the 1977 Amendments.

Nonattainment

The 1970 legislation provided for the attainment of primary NAAQS's by 1975. In many areas of the country, particularly the most industrialized States, the statutory goals were not attained. [FN18] In 1976, the 94th Congress was confronted with this fundamental problem, as well as many others respecting pollution control. As always in this area, the legislative struggle was basically between interests seeking strict schemes to reduce pollution rapidly to eliminate its social costs and interests advancing the economic concern that strict schemes would retard industrial development with attendant social costs. The 94th Congress, confronting these competing interests, was unable to agree on what response was in the public interest: legislative proposals to deal with nonattainment failed to command the necessary consensus. [FN19]

FN18. See Report of the National Commission on Air Quality, To Breathe Clean Air, 3.3-20 through 3.3-33 (1981).

FN19. Comprehensive bills did pass both Chambers of Congress; the Conference Report was rejected in the Senate. 122 Cong.Rec. 34375-34403, 34405-34418 (1976).

In light of this situation, the EPA published an Emissions Offset Interpretative Ruling in December 1976, see 41 Fed.Reg. 55524, to "fill the gap," as respondents put it, until Congress acted. The Ruling stated that it was intended to address "the issue of whether and to what extent national air quality standards established under the Clean Air Act may restrict or prohibit growth of major new or expanded stationary air pollution sources." Id., at 55524-55525. In general, the Ruling provided that "a major new source may locate in an area with air quality worse than a national

standard only if stringent conditions can be met." Id., at 55525. The Ruling gave primary emphasis to the rapid attainment of the statute's environmental goals. [FN20] Consistent with that emphasis, the construction of every new source in nonattainment areas had to meet the "lowest achievable emission rate" under the current state of the art for that type of facility. See Ibid. The 1976 Ruling did not, however, explicitly adopt or reject the "bubble concept." [FN21]

FN20. For example, it stated: "Particularly with regard to the primary NAAQS's, Congress and the Courts have made clear that economic considerations must be subordinated to NAAQS achievement and maintenance. While the ruling allows for some growth in areas violating a NAAQS if the net effect is to insure further progress toward NAAQS achievement, the Act does not allow economic growth to be accommodated at the expense of the public health." 41 Fed.Reg. 55527 (1976).

FN21. In January 1979, the EPA noted that the 1976 Ruling was ambiguous concerning this issue: "A number of commenters indicated the need for a more explicit definition of 'source.' Some readers found that it was unclear under the 1976 Ruling whether a plant with a number of different processes and emission points would be considered a single source. The changes set forth below define a source as 'any structure, building, facility, equipment, installation, or operation (or combination thereof) which is located on one or more contiguous or adjacent properties and which is owned or operated by the same person (or by persons under common control.' This definition precludes a large plant from being separated into individual production lines for purposes of determining applicability of the offset requirements." 44 Fed.Reg. 3276.

IV.

The Clean Air Act Amendments of 1977 are a lengthy, detailed, technical, complex, and comprehensive response to a major social issue. A small portion of the statute -- 91 Stat. 745-751 (Part D of Title I of the amended Act, 42 U.S.C. ss 7501-7508) -- expressly deals with nonattainment areas. The focal point of this controversy is one phrase in that portion of the Amendments. [FN22]

FN22. Specifically, the controversy in these cases involves the meaning of the term "major stationary sources" in §172(b)(6) of the Act, 42 U.S.C. §7502(b)(6). The meaning of the term "proposed source" in §173(2) of the Act, 42 U.S.C. §7503(2), is not at issue.

Basically, the statute required each State in a nonattainment area to prepare and obtain approval of a new SIP by July 1, 1979. In the interim those States were required to comply with the EPA's interpretative Ruling of December 21, 1976. 91 Stat. 745. The deadline for attainment of the primary NAAQS's was extended until December 31, 1982, and in some cases until December 31, 1987, but the SIP's were required to contain a number of provisions designed to achieve the goals as expeditiously as possible. [FN23]

FN23. Thus, among other requirements, §172(b) provided that the SIP's shall-- "(3) require, in the interim, reasonable further progress (as defined in section 171(1)) including such reduction in emissions from existing sources in the area as may be obtained through the adoption, at a minimum, of reasonably available control technology; "(4) include a comprehensive, accurate, current inventory of actual emissions from all sources (as provided by rule of the Administrator) of each such pollutant for each such area which is revised and resubmitted as frequently as may be

necessary to assure that the requirements of paragraph (3) are met and to assess the need for additional reductions to assure attainment of each standard by the date required under paragraph (1); "(5) expressly identify and quantify the emissions, if any, of any such pollutant which will be allowed to result from the construction and operation of major new or modified stationary sources for each such area; ... . "(8) contain emission limitations, schedules of compliance and such other measures as may be necessary to meet the requirements of this section." 91 Stat. 747. Section 171(1) provided: "(1) The term 'reasonable further progress' means annual incremental reductions in emissions of the applicable air pollutant (including substantial reductions in the early years following approval or promulgation of plan provisions under this part and section 110(a)(2)(I) and regular reductions thereafter) which are sufficient in the judgment of the Administrator, to provide for attainment of the applicable national ambient air quality standard by the date required in section 172(a)." Id., at 746.

Most significantly for our purposes, the statute provided that each plan shall "(6) require permits for the construction and operation of new or modified major stationary sources in accordance with section 173...." Id., 747. Before issuing a permit, §173 requires (1) the state agency to determine that there will be sufficient emissions reductions in the region to offset the emissions from the new source and also to allow for reasonable further progress toward attainment, or that the increased emissions will not exceed an allowance for growth established pursuant to §172(b)(5); (2) the applicant to certify that his other sources in the State are in compliance with the SIP, (3) the agency to determine that the applicable SIP is otherwise being implemented, and (4) the proposed source to comply with the lowest achievable emission rate (LAER). [FN24]

FN24. Section 171(3) provides: "(3) The term 'lowest achievable emission rate' means for any source, that rate of emissions which reflects-- "(A) the most stringent emission limitation which is contained in the implementation plan of any State for such class or category of source, unless the owner or operator of the proposed source demonstrates that such limitations are not achievable, or "(B) the most stringent emission limitation which is achieved in practice by such class or category of source, whichever is more stringent. "In no event shall the application of this term permit a proposed new or modified source to emit any pollutant in excess of the amount allowable under applicable new source standards of performance." The LAER requirement is defined in terms that make it even more stringent than the applicable new source performance standard developed under s 111 of the Act, as amended by the 1970 statute.

The 1977 Amendments contain no specific reference to the "bubble concept." Nor do they contain a specific definition of the term "stationary source," though they did not disturb the definition of "stationary source" contained in §111(a)(3), applicable by the terms of the Act to the NSPS program. Section 302(j), however, defines the term "major stationary source" as follows: "(j) Except as otherwise expressly provided, the terms 'major stationary source' and 'major emitting facility' mean any stationary facility or source of air pollutants which directly emits, or has the potential to emit, one hundred tons per year or more of any air pollutant (including any major emitting facility or source of fugitive emissions of any such pollutant, as determined by rule by the Administrator)." 91 Stat. 770.

V.

The legislative history of the portion of the 1977 Amendments dealing with nonattainment areas does not

contain any specific comment on the "bubble concept" or the question whether a plantwide definition of a stationary source is permissible under the permit program. It does, however, plainly disclose that in the permit program Congress sought to accommodate the conflict between the economic interest in permitting capital improvements to continue and the environmental interest in improving air quality. Indeed, the House Committee Report identified the economic interest as one of the "two main purposes" of this section of the bill. It stated: "Section 117 of the bill, adopted during full committee markup establishes a new section 127 of the Clean Air Act. The section has two main purposes: (1) to allow reasonable economic growth to continue in an area while making reasonable further progress to assure attainment of the standards by a fixed date; and (2) to allow States greater flexibility for the former purpose than EPA's present interpretative regulations afford. "The new provision allows States with nonattainment areas to pursue one of two options. First, the State may proceed under EPA's present 'tradeoff' or 'offset' ruling. The Administrator is authorized, moreover, to modify or amend that ruling in accordance with the intent and purposes of this section. "The State's second option would be to revise its implementation plan in accordance with this new provision." H.R.Rep. No. 95-294, p. 211 (1977), U.S.Code Cong. & Admin.News 1977, pp. 1077, 1290. [FN25]

FN25. During the floor debates Congressman Waxman remarked that the legislation struck "a proper balance between environmental controls and economic growth in the dirty air areas of America.... There is no other single issue which more clearly poses the conflict between pollution control and new jobs. We have determined that neither need be compromised.... "This is a fair and balanced approach, which will not undermine our economic vitality, or impede achievement of our ultimate environmental objectives." 123

Cong.Rec. 27076 (1977). The second "main purpose" of the provision -- allowing the States "greater flexibility" than the EPA's interpretative Ruling -- as well as the reference to the EPA's authority to amend its Ruling in accordance with the intent of the section, is entirely consistent with the view that Congress did not intend to freeze the definition of "source" contained in the existing regulation into a rigid statutory requirement.

The portion of the Senate Committee Report dealing with nonattainment areas states generally that it was intended to "supersede the EPA administrative approach," and that expansion should be permitted if a State could "demonstrate that these facilities can be accommodated within its overall plan to provide for attainment of air quality standards." S.Rep. No. 95-127, p. 55 (1977). The Senate Report notes the value of "case-by-case review of each new or modified major source of pollution that seeks to locate in a region exceeding an ambient standard," explaining that such a review "requires matching reductions from existing sources against emissions expected from the new source in order to assure that introduction of the new source will not prevent attainment of the applicable standard by the statutory deadline." Ibid. This description of a case-by-case approach to plant additions, which emphasizes the net consequences of the construction or modification of a new source, as well as its impact on the overall achievement of the national standards, was not, however, addressed to the precise issue raised by these cases.

Senator Muskie made the following remarks: "I should note that the test for determining whether a new or modified source is subject to the EPA interpretative regulation [the Offset Ruling] -- and to the permit requirements of the revised implementation plans under the conference bill -- is whether the source will emit a pollutant into an area which is

exceeding a national ambient air quality standard for that pollutant -- or precursor. Thus, a new source is still subject to such requirements as 'lowest achievable emission rate' even if it is constructed as a replacement for an older facility resulting in a net reduction from previous emission levels. "A source -- including an existing facility ordered to convert to coal -- is subject to all the nonattainment requirements as a modified source if it makes any physical change which increases the amount of any air pollutant for which the standards in the area are exceeded." 123 Cong.Rec. 26847 (1977).

VI.

As previously noted, prior to the 1977 Amendments, the EPA had adhered to a plantwide definition of the term "source" under a NSPS program. After adoption of the 1977 Amendments, proposals for a plantwide definition were considered in at least three formal proceedings.

In January 1979, the EPA considered the question whether the same restriction on new construction in nonattainment areas that had been included in its December 1976 Ruling should be required in the revised SIP's that were scheduled to go into effect in July 1979. After noting that the 1976 Ruling was ambiguous on the question "whether a plant with a number of different processes and emission points would be considered a single source," 44 Fed.Reg. 3276 (1979), the EPA, in effect, provided a bifurcated answer to that question. In those areas that did not have a revised SIP in effect by July 1979, the EPA rejected the plantwide definition; on the other hand, it expressly concluded that the plantwide approach would be permissible in certain circumstances if authorized by an approved SIP. It stated: "Where a state implementation plan is revised and implemented to satisfy the requirements of Part D, including the reasonable further

progress requirement, the plan requirements for major modifications may exempt modifications of existing facilities that are accompanied by intrasource offsets so that there is no net increase in emissions. The agency endorses such exemptions, which would provide greater flexibility to sources to effectively manage their air emissions at least cost." Ibid. [FN26]

FN26. In the same Ruling, the EPA added: "The above exemption is permitted under the SIP because, to be approved under Part D, plan revisions due by January 1979 must contain adopted measures assuring that reasonable further progress will be made. Furthermore, in most circumstances, the measures adopted by January 1979 must be sufficient to actually provide for attainment of the standards by the dates required under the Act, and in all circumstances measures adopted by 1982 must provide for attainment. See Section 172 of the Act and 43 FR 21673-21677 (May 19, 1978). Also, Congress intended under Section 173 of the Act that States would have some latitude to depart from the strict requirements of this Ruling when the State plan is revised and is being carried out in accordance with Part D. Under a Part D plan, therefore, there is less need to subject a modification of an existing facility to LAER and other stringent requirements if the modification is accompanied by sufficient intrasource offsets so that there is no net increase in emissions." 44 Fed.Reg. 3277 (1979).

In April, and again in September 1979, the EPA published additional comments in which it indicated that revised SIP's could adopt the plantwide definition of source in nonattainment areas in certain circumstances. See Id., at 20372, 20379, 51924, 51951, 51958. On the latter occasion, the EPA made a formal rulemaking proposal that would have permitted the use of the "bubble concept" for new installations within a plant as well as for modifications of

existing units. It explained: " 'Bubble' Exemption: The use of offsets inside the same source is called the 'bubble.' EPA proposes use of the definition of 'source' (see above) to limit the use of the bubble under nonattainment requirements in the following respects: "i. Part D SIPs that include all requirements needed to assure reasonable further progress and attainment by the deadline under section 172 and that are being carried out need not restrict the use of a plantwide bubble, the same as under the PSD proposal. "ii. Part D SIPs that do not meet the requirements specified must limit use of the bubble by including a definition of 'installation' as an identifiable piece of process equipment." [FN27]

FN27. Id., at 51926. Later in that Ruling, the EPA added: "However, EPA believes that complete Part D SIPs, which contain adopted and enforceable requirements sufficient to assure attainment, may apply the approach proposed above for PSD, with plant-wide review but no review of individual pieces of equipment. Use of only a plant-wide definition of source will permit plant-wide offsets for avoiding NSR of new or modified pieces of equipment. However, this is only appropriate once a SIP is adopted that will assure the reductions in existing emissions necessary for attainment. See 44 FR 3276 col. 3 (January 16, 1979). If the level of emissions allowed in the SIP is low enough to assure reasonable further progress and attainment, new construction or modifications with enough offset credit to prevent an emission increase should not jeopardize attainment." Id., at 51933.

Significantly, the EPA expressly noted that the word "source" might be given a plantwide definition for some purposes and a narrower definition for other purposes. It wrote: "Source means any building structure, facility, or installation which emits or may emit any regulated pollutant. 'Building, structure, facility or installation' means plant in

PSD areas and in nonattainment areas except where the growth prohibitions would apply or where no adequate SIP exists or is being carried out." Id., at 51925. [FN28]

FN28. In its explanation of why the use of the "bubble concept" was especially appropriate in preventing significant deterioration (PSD) in clean air areas, the EPA stated: "In addition, application of the bubble on a plant-wide basis encourages voluntary upgrading of equipment, and growth in productive capacity." Id., at 51932.

The EPA's summary of its proposed Ruling discloses a flexible rather than rigid definition of the term "source" to implement various policies and programs: "In summary, EPA is proposing two different ways to define source for different kinds of NSR programs: "(1) For PSD and complete Part D SIPs, review would apply only to plants, with an unrestricted plant-wide bubble. "(2) For the offset ruling, restrictions on construction, and incomplete Part D SIPs, review would apply to both plants and individual pieces of process equipment, causing the plant-wide bubble not to apply for new and modified major pieces of equipment. "In addition, for the restrictions on construction, EPA is proposing to define 'major modification' so as to prohibit the bubble entirely. Finally, an alternative discussed but not favored is to have only pieces of process equipment reviewed, resulting in no plant-wide bubble and allowing minor pieces of equipment to escape NSR regardless of whether they are within a major plant." Id., at 51934.

In August 1980, however, the EPA adopted a regulation that, in essence, applied the basic reasoning of the Court of Appeals in these cases. The EPA took particular note of the two then-recent Court of Appeals decisions, which had created the bright-line rule that the "bubble concept" should be employed in a program designed to maintain air quality

but not in one designed to enhance air quality. Relying heavily on those cases, [FN29] EPA adopted a dual definition of "source" for nonattainment areas that required a permit whenever a change in either the entire plant, or one of its components, would result in a significant increase in emissions even if the increase was completely offset by reductions elsewhere in the plant. The EPA expressed the opinion that this interpretation was "more consistent with congressional intent" than the plantwide definition because it "would bring in more sources or modifications for review," 45 Fed.Reg. 52697 (1980), but its primary legal analysis was predicated on the two Court of Appeals decisions.

FN29. "The dual definition also is consistent with Alabama Power and ASARCO. Alabama Power held that EPA had broad discretion to define the constituent terms of 'source' so as best to effectuate the purposes of the statute. Different definitions of 'source' can therefore be used for different sections of the statute.... "Moreover, Alabama Power and ASARCO taken together suggest that there is a distinction between Clean Air Act programs designed to enhance air quality and those designed only to maintain air quality.... ..... "Promulgation of the dual definition follows the mandate of Alabama Power, which held that, while EPA could not define 'source' as a combination of sources, EPA had broad discretion to define 'building,' 'structure,' 'facility,' and 'installation' so as to best accomplish the purposes of the Act." 45 Fed.Reg. 52697 (1980).

In 1981 a new administration took office and initiated a "Government-wide reexamination of regulatory burdens and complexities." 46 Fed.Reg. 16281. In the context of that review, the EPA reevaluated the various arguments that had been advanced in connection with the proper definition of the term "source" and concluded that the term should be given

the same definition in both nonattainment areas and PSD areas.

In explaining its conclusion, the EPA first noted that the definitional issue was not squarely addressed in either the statute or its legislative history and therefore that the issue involved an agency "judgment as how to best carry out the Act." Ibid. It then set forth several reasons for concluding that the plantwide definition was more appropriate. It pointed out that the dual definition "can act as a disincentive to new investment and modernization by discouraging modifications to existing facilities" and "can actually retard progress in air pollution control by discouraging replacement of older, dirtier processes or pieces of equipment with new, cleaner ones." Ibid. Moreover, the new definition "would simplify EPA's rules by using the same definition of 'source' for PSD, nonattainment new source review and the construction moratorium. This reduces confusion and inconsistency." Ibid. Finally, the agency explained that additional requirements that remained in place would accomplish the fundamental purposes of achieving attainment with NAAQS's as expeditiously as possible. [FN30] These conclusions were expressed in a proposed rulemaking in August 1981 that was formally promulgated in October. See id., at 50766.

FN30. It stated: "5. States will remain subject to the requirement that for all nonattainment areas they demonstrate attainment of NAAQS as expeditiously as practicable and show reasonable further progress toward such attainment. Thus, the proposed change in the mandatory scope of nonattainment new source review should not interfere with the fundamental purpose of Part D of the Act. "6. New Source Performance Standards (NSPS) will continue to apply to many new or modified facilities and will assure use of the most up-to-date pollution control techniques

regardless of the applicability of nonattainment area new source review. "7. In order to avoid nonattainment area new source review, a major plant undergoing modification must show that it will not experience a significant net increase in emissions. Where overall emissions increase significantly, review will continue to be required." 46 Fed.Reg. 16281 (1981).

VII.

[7] In this Court respondents expressly reject the basic rationale of the Court of Appeals' decision. That court viewed the statutory definition of the term "source" as sufficiently flexible to cover either a plantwide definition, a narrower definition covering each unit within a plant, or a dual definition that could apply to both the entire "bubble" and its components. It interpreted the policies of the statute, however, to mandate the plantwide definition in programs designed to maintain clean air and to forbid it in programs designed to improve air quality. Respondents place a fundamentally different construction on the statute. They contend that the text of the Act requires the EPA to use a dual definition -- if either a component of a plant, or the plant as a whole, emits over 100 tons of pollutant, it is a major stationary source. They thus contend that the EPA rules adopted in 1980, insofar as they apply to the maintenance of the quality of clean air, as well as the 1981 rules which apply to nonattainment areas, violate the statute. [FN31]

FN31. "What EPA may not do, however, is define all four terms to mean only plants. In the 1980 PSD rules, EPA did just that. EPA compounded the mistake in the 1981 rules here under review, in which it abandoned the dual definition." Brief for Respondents 29, n. 56.

Statutory Language

The definition of the term "stationary source" in §111(a)(3) refers to "any building, structure, facility, or installation" which emits air pollution. See supra, at 2784. This definition is applicable only to the NSPS program by the express terms of the statute; the text of the statute does not make this definition applicable to the permit program. Petitioners therefore maintain that there is no statutory language even relevant to ascertaining the meaning of stationary source in the permit program aside from §302(j), which defines the term "major stationary source." See supra, at 2786. We disagree with petitioners on this point.

The definition in §302(j) tells us what the word "major" means -- a source must emit at least 100 tons of pollution to qualify -- but it sheds virtually no light on the meaning of the term "stationary source." It does equate a source with a facility -- a "major emitting facility" and a "major stationary source" are synonymous under §302(j). The ordinary meaning of the term "facility" is some collection of integrated elements which has been designed and constructed to achieve some purpose. Moreover, it is certainly no affront to common English usage to take a reference to a major facility or a major source to connote an entire plant as opposed to its constituent parts. Basically, however, the language of §302(j) simply does not compel any given interpretation of the term "source."

Respondents recognize that, and hence point to §111(a)(3). Although the definition in that section is not literally applicable to the permit program, it sheds as much light on the meaning of the word "source" as anything in the statute. [FN32] As respondents point out, use of the words "building, structure, facility, or installation," as the definition of source, could be read to impose the permit conditions on an individual building that is a part of a plant. [FN33] A

"word may have a character of its own not to be submerged by its association." *Russell Motor Car Co. v. United States*, 261 U.S. 514, 519, 43 S.Ct. 428, 429, 67 L.Ed. 778 (1923). On the other hand, the meaning of a word must be ascertained in the context of achieving particular objectives, and the words associated with it may indicate that the true meaning of the series is to convey a common idea. The language may reasonably be interpreted to impose the requirement on any discrete, but integrated, operation which pollutes. This gives meaning to all of the terms -- a single building, not part of a larger operation, would be covered if it emits more than 100 tons of pollution, as would any facility, structure, or installation. Indeed, the language itself implies a "bubble concept" of sorts: each enumerated item would seem to be treated as if it were encased in a bubble. While respondents insist that each of these terms must be given a discrete meaning, they also argue that §111(a)(3) defines "source" as that term is used in §302(j). The latter section, however, equates a source with a facility, whereas the former defines "source" as a facility, among other items.

FN32. We note that the EPA in fact adopted the language of that definition in its regulations under the permit program. 40 C.F.R. §§51.18(j)(1)(i), (ii) (1983).

FN33. Since the regulations give the States the option to define an individual unit as a source, see 40 C.F.R. §51.18(j)(1) (1983), petitioners do not dispute that the terms can be read as respondents suggest.

We are not persuaded that parsing of general terms in the text of the statute will reveal an actual intent of Congress. [FN34] We know full well that this language is not dispositive; the terms are overlapping and the language is not precisely directed to the question of the applicability of a given term in the context of a larger operation. To the extent

any congressional "intent" can be discerned from this language, it would appear that the listing of overlapping, illustrative terms was intended to enlarge, rather than to confine, the scope of the agency's power to regulate particular sources in order to effectuate the policies of the Act.

FN34. The argument based on the text of §173, which defines the permit requirements for nonattainment areas, is a classic example of circular reasoning. One of the permit requirements is that "the proposed source is required to comply with the lowest achievable emission rate" (LAER). Although a State may submit a revised SIP that provides for the waiver of another requirement -- the "offset condition" -- the SIP may not provide for a waiver of the LAER condition for any proposed source. Respondents argue that the plantwide definition of the term "source" makes it unnecessary for newly constructed units within the plant to satisfy the LAER requirement if their emissions are offset by the reductions achieved by the retirement of older equipment. Thus, according to respondents, the plantwide definition allows what the statute explicitly prohibits -- the waiver of the LAER requirement for the newly constructed units. But this argument proves nothing because the statute does not prohibit the waiver unless the proposed new unit is indeed subject to the permit program. If it is not, the statute does not impose the LAER requirement at all and there is no need to reach any waiver question. In other words, §173 of the statute merely deals with the consequences of the definition of the term "source" and does not define the term.

Legislative History

In addition, respondents argue that the legislative history and policies of the Act foreclose the plantwide definition, and that the EPA's interpretation is not entitled to deference

because it represents a sharp break with prior interpretations of the Act.

Based on our examination of the legislative history, we agree with the Court of Appeals that it is unilluminating. The general remarks pointed to by respondents "were obviously not made with this narrow issue in mind and they cannot be said to demonstrate a Congressional desire...." *Jewell Ridge Coal Corp. v. Mine Workers*, 325 U.S. 161, 168-169, 65 S.Ct. 1063, 1067-1068, 89 L.Ed. 1534 (1945). Respondents' argument based on the legislative history relies heavily on Senator Muskie's observation that a new source is subject to the LAER requirement. [FN35] But the full statement is ambiguous and like the text of §173 itself, this comment does not tell us what a new source is, much less that it is to have an inflexible definition. We find that the legislative history as a whole is silent on the precise issue before us. It is, however, consistent with the view that the EPA should have broad discretion in implementing the policies of the 1977 Amendments.

FN35. See supra, at 2787. We note that Senator Muskie was not critical of the EPA's use of the "bubble concept" in one NSPS program prior to the 1977 amendments. See Ibid.

More importantly, that history plainly identifies the policy concerns that motivated the enactment; the plantwide definition is fully consistent with one of those concerns -- the allowance of reasonable economic growth -- and, whether or not we believe it most effectively implements the other, we must recognize that the EPA has advanced a reasonable explanation for its conclusion that the regulations serve the environmental objectives as well. See supra, at 2789-2790, and n. 29; see also supra, at 2788, n. 27. Indeed, its reasoning is supported by the public record developed in the

rulemaking process, [FN36] as well as by certain private studies. [FN37]

FN36. See, for example, the statement of the New York State Department of Environmental Conservation, pointing out that denying a source owner flexibility in selecting options made it "simpler and cheaper to operate old, more polluting sources than to trade up...." App. 128-129.

FN37. "Economists have proposed that economic incentives be substituted for the cumbersome administrative-legal framework. The objective is to make the profit and cost incentives that work so well in the marketplace work for pollution control.... [The 'bubble' or 'netting' concept] is a first attempt in this direction. By giving a plant manager flexibility to find the places and processes within a plant that control emissions most cheaply, pollution control can be achieved more quickly and cheaply." L. Lave & G. Omenn, Cleaning Air: Reforming the Clean Air Act 28 (1981) (footnote omitted).

Our review of the EPA's varying interpretations of the word "source" -- both before and after the 1977 Amendments -- convinces us that the agency primarily responsible for administering this important legislation has consistently interpreted it flexibly -- not in a sterile textual vacuum, but in the context of implementing policy decisions in a technical and complex arena. The fact that the agency has from time to time changed its interpretation of the term "source" does not, as respondents argue, lead us to conclude that no deference should be accorded the agency's interpretation of the statute. An initial agency interpretation is not instantly carved in stone. On the contrary, the agency, to engage in informed rulemaking, must consider varying interpretations and the wisdom of its policy on a continuing basis. Moreover, the fact that the agency has adopted different

definitions in different contexts adds force to the argument that the definition itself is flexible, particularly since Congress has never indicated any disapproval of a flexible reading of the statute.

Significantly, it was not the agency in 1980, but rather the Court of Appeals that read the statute inflexibly to command a plantwide definition for programs designed to maintain clean air and to forbid such a definition for programs designed to improve air quality. The distinction the court drew may well be a sensible one, but our labored review of the problem has surely disclosed that it is not a distinction that Congress ever articulated itself, or one that the EPA found in the statute before the courts began to review the legislative work product. We conclude that it was the Court of Appeals, rather than Congress or any of the decisionmakers who are authorized by Congress to administer this legislation, that was primarily responsible for the 1980 position taken by the agency.

Policy

The arguments over policy that are advanced in the parties' briefs create the impression that respondents are now waging in a judicial forum a specific policy battle which they ultimately lost in the agency and in the 32 jurisdictions opting for the "bubble concept," but one which was never waged in the Congress. Such policy arguments are more properly addressed to legislators or administrators, not to judges. [FN38]

FN38. Respondents point out if a brand new factory that will emit over 100 tons of pollutants is constructed in a nonattainment area, that plant must obtain a permit pursuant to §172(b)(6) and in order to do so, it must satisfy the §173 conditions, including the LAER requirement. Respondents

argue if an old plant containing several large emitting units is to be modernized by the replacement of one or more units emitting over 100 tons of pollutant with a new unit emitting less--but still more than 100 tons -- the result should be no different simply because "it happens to be built not at a new site, but within a pre-existing plant." Brief for Respondents 4.

In these cases, the Administrator's interpretation represents a reasonable accommodation of manifestly competing interests and is entitled to deference: the regulatory scheme is technical and complex, [FN39] the agency considered the matter in a detailed and reasoned fashion, [FN40] and the decision involves reconciling conflicting policies. [FN41] Congress intended to accommodate both interests, but did not do so itself on the level of specificity presented by these cases. Perhaps that body consciously desired the Administrator to strike the balance at this level, thinking that those with great expertise and charged with responsibility for administering the provision would be in a better position to do so; perhaps it simply did not consider the question at this level; and perhaps Congress was unable to forge a coalition on either side of the question, and those on each side decided to take their chances with the scheme devised by the agency. For judicial purposes, it matters not which of these things occurred.

FN39. See e.g., *Aluminum Co. of America v. Central Lincoln Peoples' Util. Dist.*, 467 U.S., at 390, 104 S.Ct., at 2480 (1984).

FN40. See *SEC v. Sloan*, 436 U.S., at 117, 98 S.Ct., at 1711; *Adamo Wrecking Co. v. United States*, 434 U.S. 275, 287, n. 5, 98 S.Ct. 566, 574, n. 5, 54 L.Ed.2d 538 (1978); *Skidmore v. Swift & Co.*, 323 U.S. 134, 140, 65 S.Ct. 161, 164, 89 L.Ed. 124 (1944).

FN41. See *Capital Cities Cable, Inc. v. Crisp*, 467 U.S. at 699-700, 104 S.Ct. at 2700-2701; *United States v. Shimer*, 367 U.S. 374, 382, 81 S.Ct. 1554, 1560, 6 L.Ed.2d 908 (1961).

Judges are not experts in the field, and are not part of either political branch of the Government. Courts must, in some cases, reconcile competing political interests, but not on the basis of the judges' personal policy preferences. In contrast, an agency to which Congress has delegated policy-making responsibilities may, within the limits of that delegation, properly rely upon the incumbent administration's views of wise policy to inform its judgments. While agencies are not directly accountable to the people, the Chief Executive is, and it is entirely appropriate for this political branch of the Government to make such policy choices -- resolving the competing interests which Congress itself either inadvertently did not resolve, or intentionally left to be resolved by the agency charged with the administration of the statute in light of everyday realities.

When a challenge to an agency construction of a statutory provision, fairly conceptualized, really centers on the wisdom of the agency's policy, rather than whether it is a reasonable choice within a gap left open by Congress, the challenge must fail. In such a case, federal judges -- who have no constituency -- have a duty to respect legitimate policy choices made by those who do. The responsibilities for assessing the wisdom of such policy choices and resolving the struggle between competing views of the public interest are not judicial ones: "Our Constitution vests such responsibilities in the political branches." *TVA v. Hill*, 437 U.S. 153, 195, 98 S.Ct. 2279, 2302, 57 L.Ed.2d 117 (1978).

We hold that the EPA's definition of the term "source" is a permissible construction of the statute which seeks to accommodate progress in reducing air pollution with economic growth. "The Regulations which the Administrator has adopted provide what the agency could allowably view as ... [an] effective reconciliation of these twofold ends...." *United States v. Shimer*, 367 U.S., at 383, 81 S.Ct., at 1560.

The judgment of the Court of Appeals is reversed.
It is so ordered.

Justice MARSHALL and Justice REHNQUIST took no part in the consideration or decision of these cases.

Justice O'CONNOR took no part in the decision of these cases.

APPENDIX H

COMMUNITY HOSPITAL OF CHANDLER, INC., an Arizona Corporation, d/b/a Chandler Regional Hospital,

Plaintiff-Appellant,

v.

Louis W. SULLIVAN, M.D., in his official capacity as Secretary of the United States Department of Health and Human Services,

Defendant-Appellee.

No. 90-16331.

United States Court of Appeals, Ninth Circuit.
Argued and Submitted Feb. 11, 1992.
Decided May 4, 1992.
As Amended July 10, 1992.

Hospital sought review of administrative decision by Health Care Finance Administration determining that hospital was not entitled to Medicare reimbursement payment under new "federal" rate. The United States District Court for the District of Arizona, Earl H. Carroll, J., 744 F.Supp. 203, granted motion for summary judgment by Secretary of Health and Human Services. Hospital appealed. The Court of Appeals, D.W. Nelson, Circuit Judge, held that: (1) Department's determination that new state-of-the-art facility to which hospital's operations had been transferred was not a "new hospital" within meaning of regulation did not frustrate congressional intent to ease hospitals' transition

from cost-based reimbursement to Prospective Payment System (PPS); (2) Medicare Act definition of "hospital" and provisions dealing with PPS reimbursement anticipated that hospital could be "facility" for some purposes and "institution for others"; and (3) Secretary should have adjusted hospital's base year costs to take into consideration the radical shift in its operating costs.

Reversed and remanded.

[1] FEDERAL COURTS k776
170Bk776
District court's grant of summary judgment is reviewed de novo.

[2] ADMINISTRATIVE LAW AND PROCEDURE k386
15Ak386
Agency's regulations must be consistent with overall intent behind statute.

[3] SOCIAL SECURITY AND PUBLIC WELFARE k241.10
356Ak241.10
Determination of Secretary of Health and Human Services, that new state-of-the- art facility to which hospital's operations were transferred was not a "new hospital" within meaning of regulation for Medicare reimbursement purposes, did not frustrate congressional intent to ease hospitals' transition from cost- based to Prospective Payment System (PPS) reimbursement. Social Security Act, §1801 et seq., as amended, 42 U.S.C.A. §1395 et seq.

[4] SOCIAL SECURITY AND PUBLIC WELFARE k241.5
356Ak241.5
Medicare Act definition of "hospital" and provisions of Act dealing with Prospective Payment System (PPS)

reimbursement anticipate that hospital can be "facility" for some purposes and "institution" for others. Social Security Act, §§1801 et seq., 1861(e), as amended, 42 U.S.C.A. §§1395 et seq., 1395x(e).

[5] SOCIAL SECURITY AND PUBLIC WELFARE k241.10
356Ak241.10
Secretary of Health and Human Services should have adjusted base year cost of hospital seeking Medicare reimbursement to take into consideration the radical shift in its operating costs resulting from transfer of its operations to new state-of-the-art facility. Social Security Act, §1886(b)(4)(A), as amended, 42 U.S.C.A. §1395ww(b)(4)(A).

Patrick K. O'Hare, Amy E. Hancock, McDermott, Will, & Emery, Washington, D.C., and Douglas Gerlach, Brown & Bain, Phoenix, Ariz., for plaintiff-appellant.

Stuart Gerson, Asst. Atty. Gen., James P. Loss, Asst. U.S. Atty., Phoenix, Ariz., Lawrence M. Meister, Office of the Gen. Counsel, Dept. of Health and Human Services, Baltimore, Md., for defendant-appellee.

Appeal from the United States District Court for the District of Arizona.

Before: FLETCHER, D.W. NELSON and FERNANDEZ, Circuit Judges.

D.W. NELSON, Circuit Judge:

OVERVIEW

Until 1984, Chandler Community Hospital operated in a single-story, 46-bed, small-scale facility. That year, the original facility was closed down and the operation was transferred to a brand-new, four-story, 120-bed, state-of-the-art facility that had been constructed at a nearby location. The new facility was renamed "Chandler Regional Hospital," but it kept the same licenses as the old facility; it was also owned and operated by the same individuals. The new facility had substantially higher per-patient operating costs than the old facility.

This case raises two questions. First, we must decide whether, for the purpose of calculating Medicare reimbursements, the Secretary of Health and Human Services' ("the Secretary") determination that the new facility is not a "new hospital" within the meaning of 42 C.F.R. §412.74(a)(1) frustrates the Congressional intent behind the Medicare Act. Second, we must determine whether, if the interpretation of the new hospital regulation was valid, the Secretary was nonetheless required, under 42 U.S.C. §1395ww(b)(4)(A), to otherwise adjust Chandler's reimbursement rate to take into consideration the radical shift in its operating costs.

We hold that neither 42 C.F.R. §412.74(a)(1) nor the Secretary's interpretation of that regulation to exclude Chandler from characterization as a new hospital frustrate Congressional intent. However, we find that the Secretary erred in not adjusting Chandler's base year costs as required by 42 U.S.C. §1395ww(b)(4)(A). Therefore, we reverse the district court and remand this case so that the Secretary may have an opportunity to determine whether and to what extent Chandler is entitled to adjustments under that provision. 744 F.Supp. 203. (D. Ariz. 1990).

FACTS/PROCEDURAL BACKGROUND

Overview of the Medicare Program

In 1983, Congress amended the Social Security Act to change the way it reimburses hospitals for the costs of treating Medicare patients. Before 1983, hospitals were reimbursed according to the actual costs they expended in treating each Medicare patient. Concluding that this cost-based system was inefficient because hospitals had no incentive to provide services at lower costs, Congress introduced the Prospective Payment System (PPS). Under PPS, hospitals receive a fixed, standard amount for each Medicare inpatient they treat. The amount of the payment is adjusted for each patient by using "diagnosis-related groups" (DRGs), a classification system based on the patient's condition and treatment. This amount is theoretically equal to the "average" cost per patient. Hospitals receive the per patient DRG amount no matter how much each spends on a given patient. Hospitals that treat patients for less than the DRG amount get "rewarded," while hospitals that spend more than the DRG amount must absorb the excess costs.

Recognizing that the PPS system might create financial disruption for hospitals accustomed to cost-based reimbursement, Congress designated a four- year transition period to help hospitals ease into the new system. For those four years, Congress based a hospital's reimbursement on a formula incorporating both the PPS payment amount and an amount reflecting that particular hospital's past operating costs (the hospital-specific portion --- "HSP"). Congress directed the Secretary to base the HSP on a hospital's costs for a "base-year" period of twelve months ending on or before September 30, 1983. Congress further directed that the HSP share of the formula be gradually reduced to zero

over the course of the four-year transition period; correspondingly, the PPS amount was to rise to 100 percent.

Congress recognized that for a small number of hospitals, such as new hospitals, there would be no historical cost experience from which to calculate the HSP. Although Congress passed no statute directly addressed to hospitals falling in this category, the legislative history indicates that Congress intended that the Secretary "make appropriate provision for applying a prospective payment system." H.R.Rep. No. 25, 98th Cong., 1st Sess. 137, reprinted in 1983 U.S. Code Cong. & Admin. News 219, 356. Accordingly, the Secretary issued 42 C.F.R. §412.74(a). This regulation defines "new hospitals" as follows: (a) For purposes of this section, a new hospital is a hospital that meets either of the following requirements: (1) The hospital-- (i) Is newly participating in the Medicare program (under previous and present ownership); and (ii) Does not have a 12-month cost reporting period ending before September 30, 1983. (2) The hospital is under new ownership and can document to the satisfaction of its intermediary that-- (i) Its base period reflects previous ownership and control under which the hospital's operation was deliberately phased out in expectation of sale or termination of operations; (ii) Its occupancy rate during the current period is 150 percent of the occupancy rate during the base year; (iii) Previous ownership and management took deliberate steps to curtail services in the base period by reducing operations, laying off or transferring employees to non-inpatient areas, reducing physician staff, and reducing inpatient admissions; and (iv) The change in ownership and the corresponding growth in inpatient services and occupancy occurred between the base period and the first prospective payment period. 42 C.F.R. §412.74(a). At issue in this case is 42 C.F.R. §412.74(a)(1), as it is this definition of "new hospital" that Chandler contends it satisfies. The Secretary determined that because

such facilities had no historical cost experience, they would be reimbursed from the outset at the PPS rate. 42 C.F.R. §412.74(b).[6]

Community Hospital of Chandler/
Chandler Regional Hospital

Chandler Community Hospital ("CCH"), a single-story facility located on a five-acre site, was opened in 1962. CCH was licensed for 46 beds, divided between four-bed wards and semi-private rooms. CCH closed in 1984, just before Chandler Regional Hospital ("Chandler") was opened.

Chandler is a four-story, "state-of-the-art-facility" which occupies 40 acres and is located about seven miles from the site of the old facility. Chandler is licensed for 120 beds, all in private rooms. Chandler has a 12-bed intensive care unit, an 8-bed maternity unit, a 15-bed pediatric unit and a 15- bed cardiac care unit, and it provides numerous other services not available at CCH. Chandler treats twice as many patients as CCH did, and employs a staff more than twice as large.

The administrators of CCH planned and oversaw the construction and opening of Chandler. When CCH closed in March 1984, its patients were simply transferred to Chandler. Rather than obtain new Medicare certification, Chandler's management asked the state licensing authorities to "transfer" CCH's Medicare certification to Chandler. And rather than file separate annual cost reports with Medicare,

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6 42 C.F.R. §412.74(b) provides that: For purposes of computing transition payment rates for a new hospital, HCFA will not use the hospital specific portion of the prospective payment rate. Payments to new providers will be based solely on the Federal regional and national prospective payment rates, as described in §412.70(d).

management "combined" the costs of CCH and Chandler in a single 1984 report.

Carrying out his mandate under Congressional directives, the Secretary calculated Chandler's reimbursement rate for the four-year transition period by determining that Chandler's "base-year" would be the cost year ending in December 12, 1982. In 1982, of course, the new facility did not exist; the selected base-year reflects costs incurred at CCH. Although Chandler and the Secretary disagree on the extent of the disparity, there is little question that the base-year on which the Secretary based Chandler's HSP is unrepresentative of Chandler's actual annual operating costs for the transition period. The resulting reimbursement rate is lower than the PPS reimbursement rate.

Proceedings Below

Seeking to recover additional Medicare money, Chandler filed a complaint with its fiscal intermediary. Chandler argued that it did not have an appropriate "historical cost experience," and therefore it qualified as a hospital for which the Secretary should "make appropriate provision for applying a prospective payment system." Specifically, Chandler argued that as it was both "newly participating in the Medicare program" and did not have "a 12-month cost reporting period ending before September 30, 1983," it met the definition of a "new hospital" reflected in 42 C.F.R. §412.74(a)(1). On instructions from the Health Care Financing Administration ("HCFA") (the Secretary's designee), the fiscal intermediary denied Chandler's request to be treated as a new hospital. Chandler appealed the HCFA's decision to the Provider Reimbursement Review Board (PRRB) pursuant to 42 U.S.C. §1395oo. In a 3-1 decision, the PRRB held that Chandler did not meet the

definition of "new hospital." The dissenting member of the PRRB opined that not only did Chandler qualify as a "new hospital" under 42 C.F.R. §412.74(a)(1), but also that the Secretary's failure somehow to compensate for Chandler's unique cost situation violated 42 U.S.C. §1395ww(b)(4)(A). The PRRB's decision was affirmed by the Acting Administrator of HCFA.

The Acting Administrator's decision was a final agency action pursuant to 42 U.S.C. §1395oo (f)(1). Chandler timely filed suit against the Secretary in district court; the district court rejected Chandler's arguments and granted summary judgment to the Secretary. This timely appeal ensued.

DISCUSSION

A. Standard of Review

1. A district court's grant of summary judgment is reviewed de novo. *Vance v. Hegstrom*, 793 F.2d 1018, 1022 (9th Cir. 1986); *Regents of the University of California v. Heckler*, 771 F.2d 1182, 1187 (9th Cir. 1985).

"Judicial review of Medicare reimbursement decisions is governed by the Administrative Procedure Act, 5 U.S.C. §§701-06 (1982), which requires a court to set aside agency actions found to be 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law ...' Id. at §706." *Regents*, 771 F.2d at 1187. "Although an agency's interpretation of the statutory scheme under which it operates is entitled to considerable deference, we must reject an agency's interpretation that is inconsistent with the statute's meaning." *Sunshine Health Systems v. Bowen*, 809 F.2d 1390, 1394 (9th Cir. 1987); see also *Adams House Health Care v. Bowen*, 862 F.2d 1371, 1374 (9th Cir. 1988)

("[W]e must reject agency rules that thwart the expressed intent of Congress").

B. Analysis

1. 42 C.F.R. §412.74(a)(1) and Congressional Intent - In claiming that the Secretary's "new hospital" regulation frustrates Congressional intent, Chandler advances two arguments. First, it argues that by reimbursing Chandler at a lower rate during the transition period than the rate to which Chandler is entitled after the transition period, the Secretary has frustrated Congress's intent to "give hospitals a break" during the transition period. Second, it argues that the regulation frustrates Congressional intent by defining hospital as an institution rather than a facility.

2. Congress has not explicitly identified "new hospitals" as a particular problem, or directed the Secretary to deal with them in any particular manner.[7] Therefore, because no specific provision of the Medicare Act is at issue, Chandler can only challenge the Secretary's decision if it can show that the decision conflicts with the overall purpose of the Medicare statute. An agency's regulations must be consistent with the overall intent behind a statute. *Adams House*, 862 F.2d at 1374; *Georgetown University Hospital v. Bowen*, 862 F.2d 323, 326 (D.C. Cir. 1988) ("[O]ur inquiry into congressional intent must encompass both the particular language, as well as the broader design of the statute.").

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[7] In fact, the sole reference to new hospitals is in the legislative history noted above. One statutory provision, 42 U.S.C. §1395ww(b)(5), does provide that "In the case of any hospital having any cost reporting period of other than a 12-month period, the Secretary shall determine the 12-month period which shall be used for purposes of this section." Although new hospitals would fall under this provision, the provision affects other hospitals as well. See Sunshine Health, 809 F.2d 1390.

a. Congressional Intent Regarding the Transition Period

3. Chandler's first argument centers on legislative history which indicates that Congress wanted to ease hospitals' transition from cost-based reimbursement to PPS. Both sides agree that Congress's intent in passing the 1983 amendments was to move hospitals toward providing more cost-effective health care, and that Congress created the four-year transition period in order to minimize financial disruption for hospitals accustomed to the cost-reimbursement system. As Chandler points out, the legislative history explicitly states that the purpose of the transition period was "to minimize disruptions that might otherwise occur because of a sudden change in reimbursement policy." H.R.Rep. No. 25, 98th Cong., 1st Sess. 136, reprinted in 1983 U.S. Code Cong. & Admin. News 219, 355.

Chandler, however, reads more into this sentence. It argues that Congress intended the transition period to "give hospitals a break," contending, in essence, that the four years was meant not only to minimize financial disruptions but to reduce financial hardship. This view has apparently been taken by some courts analyzing related reimbursement problems. See, e.g., *The Methodist Hospital et. al. v. Sullivan*, 1990 Medicare & Medicaid Guide (CCH) P 39,627, at 28,117, 1991 WL 263110 (D.D.C. Sept. 20, 1991) ("[B]y all outward appearances, the transition period was designed to soften the blow dealt by the new system to hospitals") (quoting *Georgetown University*, 862 F.2d at 329). Chandler thus argues that because the Secretary has interpreted his regulations so that Chandler gets less money during the transition period than after that period, the Secretary has caused a perverse result and frustrated Congressional intent.

We find Chandler's characterization of Congressional intent in this regard unpersuasive. First, and most important, Chandler ignores the sentence in the legislative history that directly precedes the sentence on which it relies so heavily. This statement reads as follows: "Payments under the new prospective payment system would not be designed to reflect a hospital's cost situation and therefore can be expected to result in Medicare reimbursement gains and losses for hospitals in relation to what they would have received under present law." H.R.Rep. No. 25, 98th Cong., 1st Sess. 136, reprinted in 1983 U.S. Code Cong. & Admin. News 219, 355 (emphasis added.) This statement indicates that Congress recognized that some hospitals would benefit financially under the PPS system. Obviously, those hospitals would receive less during the transition period--when their payments would reflect both their lower historical costs and the higher PPS amounts--than later, when their reimbursement would be based solely on the higher PPS amounts. Thus, the simple fact that some hospitals, like Chandler, "do worse" during that transition period than they do after the new reimbursement system is fully effected does not frustrate any Congressional intent.

Chandler's position is further undermined when one considers the manner in which Congress must have determined the PPS reimbursement amounts. Reimbursement amounts under PPS were designed to reflect some sort of national average for the treatment of comparable patients. Although Congress may have selected fairly low "averages," some hospitals must have been treating patients for less than the figures selected, for otherwise no hospital would be rewarded for efficiency. Obviously, this class of hospitals would not enjoy as high a reimbursement rate during the transition period as it would during the post- transition years.

Finally, we think it relevant that Congress did not write into law a provision permitting hospitals to opt for PPS and bypass the transition period altogether if they so chose. Because Congress must have known that some hospitals would be better off under PPS than during the transition period, its failure to enact such a provision seems to be a further indication that it did not design the transition period such that hospitals would get the highest reimbursement possible.

For these reasons, we find Chandler's characterization of Congressional intent vis-à-vis the transition period incorrect. 42 C.F.R. §412.74(a) does not frustrate Congressional intent merely because its application costs Chandler money.

b. Congressional Intent to Define "Hospital" as "Facility" Rather than "Institution"

4. Chandler's second argument centers on the relationship between the Secretary's interpretation of the new hospital regulation and the manner in which Congress structured the entire PPS system. In interpreting the regulation so as to exclude Chandler, the Secretary maintains that a "hospital" is not "merely a building or group of buildings," but that it is a "business organization or institution." In refusing to define Chandler as a new hospital, the Secretary focuses on the Chandler/CCH management's failure to obtain a new provider number for the new facility and their filing of a "combined" annual cost report in 1984. In response, Chandler argues that because the Secretary focuses on ownership and the continuity of legal and business entities, rather than on physical facilities and their site-specific operating costs, this interpretation is at odds with the manner in which Congress intended the Secretary to calculate a hospital's Medicare reimbursement

rates. According to Chandler, for its new facility to be saddled with costs attributable to the old CCH facility is completely contrary to Congressional intent.

The Secretary argues that its interpretation of "hospital" "coheres" with the definition of "hospital" contained in the Medicare Act, see 42 U.S.C. §1395x(e), and with the Act's Medicare provider participation requirements. Under 42 U.S.C. §1395x(e), "[t]he term 'hospital' ... means an institution which" meets certain requirements. The Secretary points out that many of these requirements make sense only as applied to business organizations. For example, a facility must have bylaws with respect to its staff of physicians, 42 U.S.C. §1395x(e)(3), and must maintain clinical records on patients, 42 U.S.C. §1395x(e)(2). The provisions dealing with the Medicare provider participation requirements, contained in 42 U.S.C. §1395cc, similarly appear to treat a hospital as a business organization required to bill patients, file paperwork with the Secretary, and renew "contracts" with the Secretary to guarantee continued participation.

For its part, Chandler relies on several provisions in the Medicare Act which seem to indicate that, for the purposes of PPS, a hospital's reimbursement rate should reflect its physical operations rather than its legal relationships. Chandler points to provisions intended to reflect differences in local wage rates, 42 U.S.C. §1395ww(d)(2)(H), and the cost differences between urban and rural hospitals, 42 U.S.C. §1395ww(d)(2)(D). Congress also directed the Secretary to account for the special needs of sole community hospitals, 42 U.S.C. §1395ww(d)(5)(C)(ii), as well as for the hardships presented by unusually costly cases, 42 U.S.C. §1395ww(d)(5)(A). Chandler also points to provisions of 42 U.S.C. §1395x(e) that seem to refer to an individual facility rather than a legal or business

organization. These provisions refer to such things as a facility's ability to attract sufficient personnel and its compliance with fire and safety requirements, 42 U.S.C. §1395x(e)(B), (C), and requirements that a facility have a licensed nurse "on duty at all times." 42 U.S.C. §1395x(e)(5). In response to the Secretary's argument regarding Medicare provider participation requirements, Chandler points out that the Secretary has elsewhere taken the position that the "provider" of Medicare services is the facility, not the institution, see *Board of Trustees of State Institutions of Higher Learning v. Sullivan*, 763 F.Supp. 178 (S.D. Miss. 1991), and that the manner in which a hospital is treated under the Medicare provider program is not necessarily dispositive of that hospital's status for PPS reimbursement. Sunshine Health, 809 F.2d 1390 (finding that qualification as a "new provider" under 42 C.F.R. §405.460(e)(2)(1985) did not mandate treatment as "new hospital" under 42 C.F.R. §412.74(a)).

Both the Secretary and Chandler mischaracterize the contents of the Medicare Act. We find that 42 U.S.C. §1395x(e) as well as those provisions dealing with PPS reimbursement anticipate that a hospital can be a "facility" for some purposes and an "institution" for others. We, of course, need not resolve this dispute in favor of either party, as the implications of this conclusion for the purposes of our inquiry are quite simple. In the absence of a clear indication of Congressional intent, we must defer to the Secretary's promulgation and interpretation of its regulations. It is well settled law that where Congress has not clearly "spoken" to a particular issue, a reviewing court must treat the Secretary's regulations with a greater degree of deference. See, e.g., *Fmali Herb, Inc. v. Heckler*, 715 F.2d 1385, 1387 (9th Cir. 1983). Chandler has not demonstrated a clear Congressional intent to define hospital in this context as a facility rather than an institution. Under these circumstances, we think that

extra degree of deference well- warranted. In short, because we can ascertain no clear Congressional intent to define "hospital" for the purposes of PPS reimbursement as a "facility," we defer to the Secretary's promulgation and interpretation of 42 C.F.R. §412.74(a)(1). The Secretary's actions are simply not "arbitrary or capricious."[8]

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[8] In challenging the Secretary's interpretation of 42 C.F.R. §412.74(a)(1), Chandler makes one final, unrelated argument: that because the decisions below are founded upon the faulty assumption that the PPS system generally will compensate for Chandler's "special circumstances," this court should overturn them. See *Villa View Community Hospital, Inc. v. Heckler*, 720 F.2d 1086, 1093-94 (9th Cir. 1983) (reversing Secretary's decision to disallow reimbursement for land use costs where Secretary wrongly assumed that Medicare regulations prohibited the amortization of certain costs). This argument has little merit. First, neither the Secretary nor the district court made its belief that Chandler would be adequately compensated by other provisions of PPS a predicate for their decision that the Secretary's decision regarding 42 C.F.R. §412.74(a)(1) was proper. In other words, those tribunals did not imply that Chandler was not a new hospital because other provisions of the PPS statute would compensate for its increased expenditures. Second, Chandler's arguments are unpersuasive in and of themselves. Chandler argues that the court below erred because "Chandler's costs per patient ... far exceeded its PPS reimbursement per patient." However, the statement alone is meaningless: the PPS system was never designed to reimburse hospitals for their actual costs per patient. Moreover, what is at issue in this case is Chandler's reimbursement during the transition period, not its PPS reimbursement amounts generally. Similarly, Chandler states that the PRRB found that "CCH's costs were 'very unrepresentative' of Chandler's costs during the transition period." Again, this statement alone is meaningless. The relevant inquiry is whether Chandler's level of reimbursement during the transition period, after the Secretary had determined a proper base-year cost, was sufficiently related to Chandler's actual costs during that period. The fact that the initial 1982 base-year reflected inordinately low costs does not, by itself, indicate a problem with the level of reimbursement ultimately settled upon.

2. The Secretary's Mandate under 42 U.S.C. §1395ww(b)(4)(A)

5. In the alternative, Chandler argues that the Secretary's failure to adjust its base-year costs to reflect the radical increase in its operating costs violates 42 U.S.C. §1395ww(b)(4)(A), which requires that a hospital's base-year costs be indicative of its actual operating costs during the transition years. Chandler contends that under this provision, the HSP integrated into a hospital's transition period reimbursement must be calculated to reflect both the hospital's historic costs and any special circumstances surrounding costs incurred during the base-year period: The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured.) 42 U.S.C. §1395ww(b)(4)(A) (emphasis added). See also H.R.Conf.Rep. No. 47, 98th Cong., 1st Sess. 181-82, reprinted in 1983 U.S. Code Cong. & Admin. News 404, 471-72 (same). Arguing that CCH's historical costs have nothing to do with Chandler's current circumstances, Chandler claims that the Secretary's failure to adjust its base-year costs violates this statute.

Although Chandler did not explicitly raise this argument below, we think it proper to consider at this time. We find that Chandler constructively raised it by arguing before the various tribunals that the Secretary's action leaves "hospitals like Chandler which constructed replacement facilities subsequent to the base year without a meaningful remedy under the regulations" and by invoking 42 U.S.C.

§1395ww(b)(4)(A) from the outset of this litigation. The record indicates that the tribunals below, as well as the Secretary, were apprised of the argument. We note in particular the dissenting opinion of Arthur Owens, PRRB member. In his opinion, Mr. Owens states that Chandler's "adjustment is in conflict with ... 42 U.S.C. §1395ww(b)(4)(A)" and that "in this case, a gross distortion occurred between the base year and the first PPS year." Similarly, before this court, the Secretary takes issue with the meaning of 42 U.S.C. §1395ww(b)(4)(A), but nowhere contends that Chandler has forfeited its right to make this argument by not raising it below. Finally, we think that a liberal construction of Chandler's argument with regard to 42 U.S.C. §1395ww(b)(4)(A) is appropriate because, as counsel for the Secretary conceded at oral argument, the Secretary has not promulgated regulations which would make clear to a facility in Chandler's position the procedure for requesting a base-year cost adjustment pursuant to that statute.

We hold that the Secretary has not fulfilled his obligations to Chandler under 42 U.S.C. §1395ww(b)(4)(A). Whether or not Chandler is a "new hospital" under 42 C.F.R. §412.74(a)(1), it is a hospital which has experienced a "distortion in the costs for the base period." To the extent that Chandler's base year reflects costs incurred at CCH, it is unrepresentative of actual costs at Chandler. The Secretary's failure to make some adjustments to this base-year cost figure violates 42 U.S.C. §1395ww(b)(4)(A)'s requirement that the Secretary "shall provide for an exemption from, or an exception to adjustment to" the normal process of calculating a hospital's base year cost. The Secretary's argument that Chandler has been adequately reimbursed because the case mix index and per patient DRG level have risen at the new facility is of no moment. The provision in question clearly speaks of adjustments to the base-year costs,

not of adjustments to the final reimbursement rate, adjustments to which all hospitals are entitled.

Few other courts have had the opportunity to consider the relationship between 42 U.S.C. §1395ww(b)(4)(A) and the calculation of a hospital's base year cost under PPS. However, a majority of those that have agrees that Congress intended the section to function as a general mechanism for making the reimbursement system practical and equitable. For example, in *Newport Hospital and Clinic, Inc. v. Sullivan*, 1990 Medicare & Medicaid Guide (CCH) P 38,844, 1990 WL 179953 (D.D.C. Sept. 14, 1990), the Secretary agreed to adjust Newport's base year costs where Newport had started the relevant year in a small facility and later moved to a larger facility with more patients and staff. The Secretary refused, however, to apply the adjustment retroactively to the transition period. The court held that under 42 U.S.C. §1395ww(b)(4)(A), the Secretary was required to make the adjustment apply retroactively. The court went on to note that even though Newport's situation did not fit neatly into the Secretary's regulations, the Secretary "was authorized and perhaps required" to grant the adjustments to Newport's base year costs pursuant to 42 U.S.C. §1395ww(b)(4)(A). Id. at 24,063-64. Similarly, in *The Methodist Hospital v. Sullivan*, 1990 Medicare & Medicaid Guide (CCH) P 39,627, 1991 WL 263110 (D.D.C. Sept. 20, 1991), Methodist Hospital argued that the base year cost the Secretary calculated for it did not adequately reflect its actual operating costs due to certain capital improvement expenditures. The district court remanded the case to the Secretary with instructions that he adjust the base year cost in accordance with 42 U.S.C. §1395(b)(4)(A). But see *Sacred Heart Medical Center v. Sullivan*, 958 F.2d 537, 549

(3rd Cir. 1992) (finding that Congress did not intend that 42 U.S.C. §1395ww(b)(4)(A) be incorporated into the PPS).[9]

Chandler's move from an old facility to a new facility created a distortion in its hospital costs. Chandler's unusual circumstances are precisely the "difficult to anticipate" sort that Congress could not provide for, and thus enacted 42 U.S.C. §1395ww(b)(4)(A) to cover. By failing to take steps to calculate an appropriate, alternative base-year cost for Chandler, the Secretary has frustrated the Congressional intent embodied in that statute.

CONCLUSION

We REVERSE the decision of the district court and REMAND this case to the Secretary of Health and Human Services. Although we uphold the Secretary's determination

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[9] In Sacred Heart, the Secretary expressly took the position that Congress did not intend to incorporate 42 U.S.C. §1395ww(b)(4)(A) into the PPS. Before us, by contrast, the debate has centered on whether or not Chandler is entitled to adjustment. At oral argument, for example, the Secretary acknowledged that regulations that clarify the procedure for requesting adjustment under 42 U.S.C. §1395ww(b)(4)(A) have not yet been promulgated. The Secretary has not maintained that 42 U.S.C. §1395ww(b)(4)(A) is simply not applicable. In any event, we find that Congress did intend to incorporate §1395ww(b)(4)(A). As we have noted before, "although the PPS is basically embodied within 42 U.S.C. §1395ww(d) ... there is clear interface between §1395ww subsections (b) and (d)." Sunshine Health, 809 F.2d at 1398. In Sunshine Health, we rejected the Secretary's argument that Congress did not intend to incorporate §1395ww(b)(5). Id. The Secretary had conceded that PPS target amount calculations were based in part on §1395ww(b)(3)(A). Thus, in light of the fact that §1395ww(d) "by its own terms incorporates one of the main concepts of subsection (b)," we found it illogical to exclude from PPS other subsections of §1395ww(b). Id. That reasoning applies with equal force here: it would be equally illogical to exclude §1395ww(b)(4).

that Chandler Hospital is not a "new hospital" within the meaning of 42 C.F.R. §412.74(a)(1), we find that Chandler is entitled to adjustments to its base year costs under 42 U.S.C. §1395ww(b)(4)(A). We remand the case to the Secretary so that he may determine the extent of Chandler's entitlements under that statute. The Secretary is also directed to award Chandler interest as appropriate under 42 U.S.C.A. §139500(f)(2).

APPENDIX I

EPISCOPAL HOSPITAL, et al.,

Appellants,

v.

Donna E. SHALALA, Secretary,
Health and Human Services.

Nos. 92-5033, 92-5034.

United States Court of Appeals,
District of Columbia Circuit.

Argued March 18, 1993.
Decided June 18, 1993.

Short term acute care hospitals providing in-patient care under Medicare program requested order compelling Secretary of Health and Human Services to make adjustment to base year costs to include costs associated with care furnished to Medicare beneficiaries for hospitalization after their Medicare coverage had been exhausted for purposes of calculating hospital specific portion (HSP) of Prospective Payment System (PPS) rates. The United States District Court for the District of Columbia, Norma Holloway Johnson, J., ruled in favor of Secretary, and appeal was taken. The Court of Appeals, Sentelle, Circuit Judge, held that: (1) plain language of PPS statute and its implementing regulations supported Secretary's contention that PPS did not include "emergency circumstances" provision, and

(2) Secretary's interpretation of PPS statute was neither arbitrary, capricious nor unlawful.

Affirmed.

[1] SOCIAL SECURITY AND PUBLIC WELFARE k241.10
356Ak241.10
To extent that Prospective Payment System (PPS) statute was ambiguous, Secretary of Health and Human Services' interpretation of statute as precluding adjustment of base year costs to include costs associated with care furnished to Medicare beneficiaries for hospitalization after their Medicare coverage had been exhausted for purpose of calculating hospital specific portion (HSP) of PPS rates was permissible. Social Security Act, §1886(d), as amended, 42 U.S.C.A. §1395ww(d).

[2] ADMINISTRATIVE LAW AND PROCEDURE k763
15Ak763
Under Administrative Procedure Act (APA), Court of Appeals holds unlawful and sets aside only those agency actions that Court finds arbitrary, capricious, abuse of discretion or otherwise not in accordance with law. 5 U.S.C.A. §706(2)(A).

[3] SOCIAL SECURITY AND PUBLIC WELFARE k241.5
356Ak241.5
Plain language of Prospective Payment System (PPS) statute and its implementing regulations supported Secretary of Health and Human Services' contention that PPS did not include "emergency circumstances" provision. Social Security Act, §1886(d), as amended, 42 U.S.C.A. §1395ww(d).

[4] SOCIAL SECURITY AND PUBLIC WELFARE k241.10
356Ak241.10
Secretary of Health and Human Services' interpretation of Prospective Payment System (PPS) statute as precluding adjustment of base year costs to include costs associated with care furnished to Medicare beneficiaries for hospitalization after their Medicare coverage had been exhausted for purposes of calculating hospital specific portion (HSP) of PPS rates was neither arbitrary, capricious, nor unlawful. Social Security Act, §1886(d), as amended, 42 U.S.C.A. §1395ww(d).

Appeals from the United States District Court for the District of Columbia.

Mark H. Gallant, Philadelphia, PA, argued the cause for appellants.

Linda A. Ruiz, Atty., Dept. of Health and Human Services, Washington, DC, argued the cause for appellee. With her on the briefs were Stuart M. Gerson, Asst. Atty. Gen., Jay B. Stephens, U.S. Atty. at the time the brief was filed, and John D. Bates, Asst. U.S. Atty. R. Craig Lawrence, Asst. U.S. Atty., Washington, DC, also entered an appearance for appellee.

Before EDWARDS, SENTELLE, and HENDERSON, Circuit Judges.

Opinion for the Court filed by Circuit Judge SENTELLE.

SENTELLE, Circuit Judge:

This is an appeal from a District Court judgment upholding the validity of regulations issued by the Secretary

of Health and Human Services (the "Secretary") under 42 U.S.C. §1395ww(d) (1988), which sets forth the methodology for calculating hospitals' Medicare cost reimbursement under the Prospective Payment System ("PPS"). Appellants argue that the Secretary's PPS regulations are based in part on an erroneous interpretation of the enabling statute, or are arbitrary and capricious. The District Court disagreed; we reach the same result and therefore affirm the District Court's judgment.

I. BACKGROUND

A. Statutory and Regulatory Framework

Part A of the Medicare Program, 42 U.S.C. §1395c et seq. (1988 & 1991 Supp. III), authorizes payment for primary institutional care, such as hospital services, to eligible aged and disabled persons. Providers of these services are reimbursed by fiscal intermediaries designated by the provider and the Secretary. 42 U.S.C. §1395h (1988); 42 C.F.R. §421.103 (1992). Under Part A, Medicare beneficiaries receive coverage for 90 days of hospital inpatient services in each benefit period, as defined by the statute and regulations, plus an additional 60-day lifetime reserve. 42 U.S.C. §1395d (1991 Supp. III); 42 U.S.C. §1395q (1988); 42 C.F.R. §409.60 et seq. (1992).

Until October of 1983, the Medicare Program reimbursed hospitals and other health care providers for the "reasonable cost" of covered services, defined as the "cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. §1395x(v) (1988). Under this reasonable-cost regime, hospitals providing inpatient care to Medicare patients received reimbursement for allowable operating costs of services provided to patients,

but only to the extent the services were provided on days for which the patients had Medicare coverage. Id. §1395q(d).

Concerned that hospitals had little incentive to reduce or contain costs because reasonable cost reimbursement shifts the burden of cost increases from hospitals to the federal government, Congress enacted provisions in the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), Pub.L. No. 97-248, 96 Stat. 324 (1982) (codified at scattered sections of 42 U.S.C.), to address containment of Medicare costs. While the TEFRA provisions left the basic retrospective, cost-based structure of Part A reimbursement undisturbed, it imposed a limit on the rate of increase of Part A reimbursement.

Under TEFRA, the rate-of-increase limit for each hospital was tied to a "target amount." This amount was the hospital's allowable costs of inpatient hospital services for the preceding cost reporting period, increased by a specified percentage in each succeeding cost reporting period. 42 U.S.C. §1395ww(b)(3)(A) (1988). Though hospitals were subject to reductions in the amount of their Part A reimbursements if their operating costs exceeded the applicable target amounts, id. §1395ww(b)(1)(B), they received bonuses if their operating costs were less than their target amounts. Id. §1395ww(b)(1)(A); 42 C.F.R. §413.40 (1992).

TEFRA also set out specific exceptions and adjustments to the new limits. Section 1395ww(b)(4)(A) directed the Secretary to "provide for an exemption from, or an exception and adjustment to, the [rate of increase] method ... where events beyond the hospital's control or extraordinary circumstances ... create a distortion in the increase in costs for a cost reporting period." 42 U.S.C. §1395ww(b)(4)(A). In addition, the subsection authorized

the Secretary to "provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate." Id.; see also 42 C.F.R. §413.40(f)-(g) (exemptions and adjustments).

In 1983, Congress replaced the TEFRA-mandated system with a more radical reform of inpatient cost reimbursement, known as the Prospective Payment System. See Pub.L. No. 99-272, §9102, 100 Stat. 155 (1986) (codified as amended, 42 U.S.C. §1395ww(d) (1988 & 1991 Supp. III)); 42 C.F.R. §412.1 et seq. (1992). Under this system, hospitals and other health care providers are reimbursed on the basis of prospectively determined national and regional rates, rather than reasonable operating costs. The system classifies Medicare patients into one of approximately 470 "diagnosis related groups" ("DRGs") based on differences in patients' utilization of hospital resources by groups and establishes fixed rates for each. The PPS rates do not vary according to the actual costs of individual cases, but are designed to allow efficient providers to recover their average costs of serving Medicare patients during a cost reporting period.

In enacting the PPS, Congress simultaneously provided for various exceptions and adjustments, as it had when it enacted TEFRA's rate-of-increase limit. Section 1395ww(d)(5) directs the Secretary to implement specific exceptions and adjustments, 42 U.S.C. §1395ww(d)(5)(A)-(H), and to provide by regulation for other exceptions and adjustments to payment amounts "as the Secretary deems appropriate." Id. §1395ww(d)(5)(I). In contrast to the analogous provision in TEFRA, however, §1395ww(d)(5)(I) does not direct the Secretary to adjust reimbursement amounts where "extraordinary circumstances" distort the increase in costs for a particular cost reporting period.

Though eager to restrain health care costs, Congress recognized that immediate institution of the PPS could pose financial hardship for many health care providers. It therefore created a four-year transition period between the reasonable cost system and the PPS, 42 U.S.C. §1395ww(d), designed to "minimize disruptions that might otherwise occur because of a sudden change in reimbursement policy." H.R.REP. NO. 25, 136, 98th Cong., 1st Sess., reprinted in 1983 U.S.C.C.A.N. 143, 355.

During the transition period, the government was required to reimburse hospitals for inpatient hospital services according to a "blended" rate, based upon two components. The first was the hospital-specific portion ("HSP"), defined as a hospital's "allowable operating costs of inpatient hospital services" in a prior base year, i.e., the Medicare cost year ending on or after September 30, 1982. 42 U.S.C. §1395ww(b)(3)(A). The HSP is a percentage of the hospital's target amount as defined in subsection (b)(3)(A). The second element was the "federal" portion, a computation from regional and national DRG rates approaching the PPS rate. 42 U.S.C. §1395ww(d)(2)(A), (B). Over the course of the four-year transition period, the portion of the reimbursement amount attributable to the prospective rate became progressively larger and HSP progressively smaller, until the prospective rate formed the exclusive basis for PPS reimbursement at the end of the transition period. Id. §1395ww(d)(1)(C).

In implementing the PPS, the Secretary promulgated regulations modifying prior Medicare coverage rules. See 48 Fed. Reg. 39,752 (1984) (codified at 42 C.F.R. §405 et seq. (1992)). Inpatient hospital stays involving at least one day of Medicare eligibility would be treated as fully "covered" stays under Part A, for which the PPS payment itself would represent payment in full, regardless of the length of stay or

extra costs attending the patient's recovery. 42 C.F.R. §412.2(b)(2) (1992) (formerly 42 C.F.R. §405.70(b)(2)(ii) (1984)). Because hospitals were prohibited from billing costs not fully reimbursed by Medicare, id. §412.42(a), the "balance," in effect, was no longer reimbursable.

B. Facts

Appellants in this case are seven short-term acute care hospitals providing inpatient care under the Medicare program. Through their fiscal year ending June 30, 1984, appellants received reimbursement under the reasonable cost system. During the transition years, their PPS rates, including the HSP, were calculated by their intermediaries before the start of their first year under the PPS and were annually updated and used to determine their PPS payments per discharge. Excluded from the base-year costs were costs associated with care furnished to Medicare beneficiaries for hospitalization after their Medicare coverage had been exhausted, costs for which Medicare had reimbursed the hospitals under the reasonable cost system. The hospitals sought an adjustment from their intermediaries to include these costs in the base-year totals, for purposes of calculating the HSP of their PPS rates. The intermediaries declined to adjust the costs because the Secretary's regulations did not provide for such an adjustment. The hospitals appealed to the Provider Reimbursement Review Board, which, on April 12, 1989, certified the issue for expedited judicial review pursuant to 42 U.S.C. §1395oo(f) (1988).

The hospitals then filed the present action in the United States District Court on June 15, 1989, requesting an order compelling the Secretary to compensate them for costs that were improperly excluded from the hospital- specific portions of their transition-year payment rates. On cross-motions for summary judgment, the District Court reviewed

the record and concluded that the Secretary had acted lawfully in not providing for adjustments to hospitals' base-year costs to reflect costs associated with care furnished to patients after their Medicare coverage had been exhausted. Episcopal Hosp. v. Sullivan, Medicare & Medicaid Guide, (CCH) P 39,817, 1991 WL 330924 (D.D.C. 1991). The court assumed, without discussion, that 42 U.S.C. §1395ww(b)(4)(A), which authorizes the Secretary to make adjustments in "extraordinary circumstances," applies to transition rates under PPS. However, the court upheld as based on a permissible reading of the statute the Secretary's conclusion that promulgation of a new regulation treating exhausted stays differently than under reasonable cost reimbursement was not an event "beyond the hospital's control or extraordinary circumstances" within the meaning of §1395ww(b)(4)(A). The court also concluded that the Secretary did not abuse her discretion under §1395ww(d)(5)(D) to provide the adjustment the hospitals sought.

This appeal followed.

II. DISCUSSION

Appellants argue in the first instance that the plain meaning of the enabling statute required the Secretary to make adjustments they seek. In the alternative, they argue that even if the statute does not require the Secretary to make the requested adjustments, the Secretary's refusal to make the base- year adjustments was arbitrary and capricious.

Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984), provides the proper framework for the statutory interpretation issue. That case held that first, always, is the question whether Congress has directly spoken to the precise

question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.... [However,] if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute. Id. at 842-43, 104 S.Ct. at 2781.

Appellants rely on §1395ww(b)(4)(A), which states that "[t]he Secretary shall provide for an exemption from. or an exemption and adjustment to, the [statutory rate of increase] method ... where events beyond the hospital's control or extraordinary circumstances ... create a distortion in the increase in costs for a cost reporting period." 42 U.S.C. §1395ww(b)(4)(A). They note that §1395ww(d)(1)(A)(i)(I) incorporates by reference the TEFRA "target rate" definition of subsection (b)(3), for purposes of setting the PPS base-period, hospital-specific costs. Subsection 1395ww(b)(3), they argue, is in turn subject to the provisions of subsection 1395ww(b)(4)(A), which requires the Secretary to make adjustments to the target rate in "extraordinary circumstances." Id. §1395ww(b)(4)(A). Thus, appellants conclude that §1395ww(d)(1) explicitly incorporates subsection (4)(A)'s extraordinary- circumstances mandate.

We do not agree. Section 1395ww(b)(3)(A), defining "target amount," plainly does not incorporate subsection (b)(4)(A). In fact, §1395ww(b)(3)(A) never mentions that subsection, although it does refer to other exceptions from the target amount method determined under subparagraph (b)(3)(A). See 42 U.S.C. §1395ww(b)(3)(A). Nor does subsection (b)(4)(A) either define "target amount" or modify the definition set forth in (b)(3)(A). In fact, subsection (b)(4)(A) explicitly authorizes the Secretary to depart from the "target amount" benchmark in (b)(3)(A) in specific circumstances, suggesting that incorporation of (b)(4)(A) might conflict with the congressional intent partially to base reimbursement on the target amount during the PPS transition period.

Certainly, the fact that Congress clearly incorporated subsection (b)(3)(A), while never referring to subsection (b)(4)(A), suggests that when Congress intended to incorporate a TEFRA provision into PPS, it did so expressly and that it did not intend to incorporate the provision at issue here.

Furthermore, appellants are unable to reconcile their argument with §1395ww(d)(5). That section mandates specific adjustments and exceptions to the amount a hospital may be reimbursed for its inpatient operating costs under the PPS, see §1395ww(d)(5)(A)-(H), and gives the Secretary general authority to provide for other exceptions and adjustments "as the Secretary deems appropriate." Id. §1395ww(d)(5)(I). The quoted language also appears in subsection (b)(4)(A); significantly, however, subsection (d)(5) contrasts with subsection (b)(4)(A), insofar as the former does not include a provision for upward modification of a hospital's target rate in "extraordinary circumstances." Compare 42 U.S.C. §1395ww(d)(5)(I) with id. §1395ww(b)(4)(A).

In light of the foregoing, not only are we unable to agree with appellants that the statute requires the Secretary to make the requested adjustments, but it appears that the meaning may be quite the contrary. Even if we admit the possibility of other interpretations, appellants still do not prevail. Under the second step of *Chevron*, we "need not conclude that the agency construction was the only one it permissibly could have adopted to uphold the construction, or even the reading the court would have reached if the question initially had arisen in a judicial proceeding." *Chevron*, 467 U.S. at 843 n. 11, 104 S.Ct. at 2781 n. 11. We need only determine "whether the agency's answer is based on a permissible construction of the statute." Id. at 843, 104 S.Ct. at 2781. In short, to the extent that the statute is

ambiguous, the Secretary's interpretation, which is a permissible one for the reasons given above, must be upheld.

Having upheld the Secretary's reading of the statute under the *Chevron* analysis, we turn to appellants' second argument, that the Secretary's promulgation and application of the implementing regulations was arbitrary and capricious.

The appropriate standard for reviewing the Secretary's exercise of the discretion afforded under the statute is dictated by 42 U.S.C. §1395oo(f)(1), which incorporates the Administrative Procedure Act ("APA"), 5 U.S.C. §706(2)(A) (1988). Under the APA, we hold unlawful and set aside only those agency actions that we find "arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law." Id. Insofar as the question of whether the Secretary's regulations are in accordance with law, it follows from our analysis above the Secretary acted consistently with the statutory mandate, and in furtherance of the congressional goals.

As to the argued arbitrariness or capriciousness of the form she chose for doing so, we have often made it plain that we do not sit to interfere with the policy decisions of an agency, *Ethyl Corp. v. EPA*, 541 F.2d 1, 34 (D.C. Cir.) (en banc), *cert. denied*, 426 U.S. 941, 96 S.Ct. 2662, 49 L.Ed.2d 394 (1976) (noting that this Court is "forbidden from substituting [our] judgment for that of the agency"), and we will not do so here. A review of the Secretary's official explanation of the final rules, 49 Fed.Reg. 234, 246- 49 (1984), reveals that the Secretary responded to the comments that were in fact submitted. She revealed her goals and reasoning. She gave us a record which "will enable us to see what major issues of policy were ventilated by the ... proceedings and why the agency reacted to them as it did." *Walter O. Boswell Mem. Hosp. v. Heckler*, 749 F.2d 788,

794 (D.C. Cir. 1984) (internal quotation marks omitted). She did, in short, all that the APA required.

We note that the root cause of appellants' objection to the PPS implementing regulations lies not in the refusal of adjustments, but rather in 42 C.F.R. §412.42(a), which prohibits hospitals from charging Medicare patients whose bills exceed the amount paid to the hospital under the PPS. That regulation reads as follows: A hospital may not charge a beneficiary for any services for which payment is made by Medicare, even if the hospital's cost of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment systems. Id. Obviously, this regulation may prevent health care providers from recouping losses which they may sustain when a Medicare patient remains with them beyond the average stay per ailment or requires greater than average care. There is, however, nothing we can do for appellants in this regard as they have not challenged §412.42(a), but only the Secretary's discretionary refusal to adjust the base-year computations to offset the effect of the change in regulations. See *Association of Accredited Cosmetology Schools v. Alexander*, 979 F.2d 859, 862 (D.C. Cir. 1992) (courts ordinarily do not address new legal theories on appeal).

III. CONCLUSION

For the reasons set forth above, we hold that the plain language of the PPS statute and its implementing regulations support the Secretary's contention that the PPS does not include an "emergency circumstances" provision. Further, the Secretary's implementation of the statute was neither arbitrary, capricious, nor unlawful. Therefore, the judgment of the District Court is hereby

Affirmed.

APPENDIX J

GOOD SAMARITAN HOSPITAL, ET AL.,
PETITIONERS
v.
DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES
No. 91-2079
SUPREME COURT OF THE UNITED STATES

Argued March 22, 1993
Decided June 7, 1993

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

U.S. LAW WEEK HEADNOTE

HEALTH CARE
Medicare

Medicare provider reimbursement statute requiring government to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive," 42 USC 1395x(v)(1)(A)(ii), is ambiguous, but secretary of health and human services' interpretation permitting only year-end book balancing of monthly advance payments with amount determined to be reasonable under applicable regulations, rather than permitting reimbursement of all actual costs that are shown to be reasonable by providers, is reasonable and entitled to

deference. (*Good Samaritan Hospital v. Shalala*, No. 91-2079).

SYLLABUS OF THE COURT

Title 42 U.S.C. §1395f(b)(1) requires the Secretary of Health and Human Services to reimburse the lesser of the "customary charges" or the "reasonable costs" of providers of health care services to Medicare beneficiaries, while §1395x(v)(1)(A) empowers the Secretary to issue regulations setting forth the methods to be used in computing reasonable costs, which may include the establishment of appropriate cost limits. Regulations issued pursuant to that authority impose such limits based on a range of factors designed to approximate the cost of providing general routine patient service, but permit various exceptions, exemptions, and adjustments to the limits. After their costs during the relevant period exceeded the corresponding cost limits, petitioner providers filed an administrative appeal challenging the limits' validity. In ruling for petitioners on expedited review, the District Court adopted their interpretation that 42 U.S.C. §1395x(v)(1)(A)(ii) (clause (ii))-which requires the regulations to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive"-entitled them to reimbursement of all costs they could show to be reasonable, regardless of whether the costs surpassed the amount calculated under the regulations' cost limit schedule. In reversing, the Court of Appeals reasoned that petitioners' request for adjustments would amount to a retroactive change in the methods used to compute costs that would be invalid under *Bowen v. Georgetown University Hospital*, 488 U. S. 204. Instead, the court adopted the Secretary's

interpretation that clause (ii) permits only a year-end book balancing to reconcile the actual "reasonable" costs under the regulations with the interim, advance payments that the statute requires to be made during the year based on the provider's approximate, anticipatory estimates of what its reimbursable costs will be. Held: Clause (ii) does not require the Secretary to afford petitioners an opportunity to establish that they are entitled to reimbursement for costs in excess of the limits stated in the regulations. Pp. 6-18. (a) Clause (ii)'s language does not itself clearly settle the matter at issue, but is ambiguous as to which of the parties' interpretations is correct. Pp. 6-9. (b) While *Georgetown*, supra, eliminated across-the-board retroactive rulemaking from the scope of clause (ii), it did not foreclose either of the parties' interpretations of the statute. Pp. 1011. (c) Confronted with an ambiguous statutory provision, this Court generally will defer to a permissible interpretation espoused by the agency entrusted with its implementation, particularly when the agency's construction is contemporaneous. By providing in more than one instance for the year-end book-balancing adjustment that, in the Secretary's view, is mandated by clause (ii), regulations promulgated soon after Medicare's enactment support the Secretary's current approach. On the other hand, those regulations nowhere mentioned a mechanism for implementing the kind of substantive recalculation and deviation from approved methods suggested by petitioners. Moreover, the agency's development-and continued augmentation- of the various exceptions, exemptions, and adjustments to the cost limits is difficult to harmonize with an interpretation of clause (ii) that would give a provider the right to contest the application of any particular and statutorily authorized method to its own circumstances. Rather, it is consistent with a view that the cost limits by definition entailed generalizations that would benefit some subscribers while harming others, and with a desire to refine these approximations through the Secretary's

creation of exceptions and exemptions. Pp. 11-13. (d) The Court rejects petitioners' argument that any deference to the agency's current position is precluded by the fact that, over the years, the agency has shifted from a book-balancing approach to a retroactive rulemaking approach and then back again. The Secretary responds that such inconsistency is attributable to the lower courts' erroneous interpretations of clause (ii) and points out that the agency returned to its initial position following *Georgetown*. How much weight should be given to the agency's views in such a situation will depend on the facts of individual cases. Cf. *FEC v. Democratic Senatorial Campaign Committee*, 454 U. S. 27, 37. Pp. 13-15. (e) In the circumstances of this case, the Court defers to the Secretary's interpretation of clause (ii). Her restrictive reading of the clause is at least as plausible as petitioners', closely fits the design of the statute as a whole and its objects and policy, and does not exceed her statutory authority, but comports with §1395x(v)(1)(A)'s broad delegation to her. Pp. 15-17.

952 F.2d 1017, affirmed.

WHITE, J., delivered the opinion of the Court, in which REHNQUIST, C. J., and BLACKMUN, O'CONNOR, KENNEDY, and THOMAS, JJ., joined. SOUTER, J., filed a dissenting opinion, in which STEVENS and SCALIA, JJ., joined.

FULL TEXT OF OPINION

JUSTICE WHITE delivered the opinion of the Court.

As a means of providing health care to the aged and disabled, Congress enacted the Medicare program in 1965. See Title XVIII of the Social Security Act, 79 Stat. 291, as amended, 42 U.S.C. §1395 et seq. Under the program, providers of

health care services can enter into agreements with the Secretary of Health and Human Services pursuant to which they are reimbursed for certain costs associated with the treatment of Medicare beneficiaries. To operate the program, the Secretary issued regulations imposing limits on the amount of repayment based on a range of factors designed to approximate the cost of providing general routine patient service. The question before us is whether the Secretary must afford the six petitioning hospitals an opportunity to establish that they are entitled to reimbursement for costs in excess of such limits.

I.

A. A complex statutory and regulatory regime governs reimbursement, rough description of which is necessary background to this case. To begin, Congress has required the Secretary to repay the lesser of the "reasonable cost" or "customary charge." See 42 U.S.C. §1395f(b)(1). Rather than attempt to define "reasonable cost" with precision, Congress empowered the Secretary to issue appropriate regulations setting forth the methods to be used in computing such costs. See 42 U.S.C. §1395x(v)(1)(A). [FN1] Prior to 1972, the Secretary's regulations contemplated reimbursement of the entirety of a provider's services to Medicare patients unless its costs were found to be "substantially out of line" with those of similar institutions. See, e.g., 20 C.F.R. §405.451(c) (1967). [FN2] In 1972, apparently fueled by concern that providers were passing on inefficient and excessive expenses, see H. R. Rep. No. 92-231, pp. 82-85 (1971); S. Rep. No. 92-1230, pp. 188-189 (1972), Congress amended the statute to specify that "reasonable costs" meant only those "actually incurred, excluding therefrom any part of incurred cost s found to be unnecessary in the efficient delivery of needed health services," 42 U.S.C. §1395x(v)(1)(A), and to authorize the

Secretary-as part of the "methods" of determining costs-to establish appropriate cost limits. See 42 U.S.C. §1395x(v)(1)(A). Accordingly, the Secretary promulgated regulations, updated yearly and establishing routine cost limits based on factors such as the type of health care provider (hospitals, skilled nursing facility, etc.), type of services it rendered, its geographical location, size, and mix of patients treated. See 20 C.F.R. §405.460 (1975). Hospitals are divided in terms of bed size, and of whether they are urban-i.e., located in a Standard Metropolitan Statistical Area (SMSA)-or rural. As of 1979, the labor-related component of provider costs was to be determined by a wage index keyed to the hospital's location. See, e.g., 46 Fed. Reg. 33637 (1981). The regulations generally provide that reimbursable costs must be within the cost limits. The regulations also allow for adjustments to the limits as applied to a provider's particular claim. A provider classified as a rural hospital can apply for reclassification as an urban one. 42 C.F.R. §413. 30(d) (1992). An exemption from the applicable cost limits can be obtained under certain specified situations - e.g., when excess expenses are due to "extraordinary circumstances," when the provider is the sole hospital in a community, a new provider, or a rural hospital with fewer than fifty beds. §413.30(e). In addition, exceptions are available for, inter alia, "atypical services," extraordinary circumstances beyond the provider's control, unusual labor costs, or essential community services. §413.30(f). [FN3] Two statutory provisions are of central importance to this litigation. First, apparently to protect providers' liquidity, the statute contemplates a system of interim, advance payments during the year. Specifically, the Secretary "shall periodically determine the amount which should be paid . . . and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) . . . the amounts so determined, with necessary adjustments on account of

previously made overpayments or underpayments." 42 U.S.C. §1395(g)(a). These interim payments by definition are only approximate ones, based on the provider's preaudit, estimated costs of anticipated services. See 42 C.F.R. Sections 413.64(e), (f) (1992). Second, the regulations were required to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. §1395x(v)(1)(A)(ii) (clause (ii)).

B. Petitioners are six Nebraska hospitals certified as "providers" of health care services and classified as "rural" for Medicare purposes. Between 1980 and 1984, their costs exceeded the corresponding cost limits. Pursuant to 42 U.S.C. §1395oo, they filed an appeal to the Provider Reimbursement Review Board (PRRB) in which they challenged the validity of the applicable cost limits on two grounds. First, they claimed that the wage index that was used to calculate reasonable cost of labor did not account for the use of part-time employees. Because petitioners used a greater proportion of part-time employees than the national average, this had the effect of artificially lowering their index values. In support of their claim, they pointed to Congress' decision in 1983 ordering the Secretary to conduct a wage index study to consider the distortion due to part-time employment, Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. 98-369, §2316(a) 98 Stat. 1081, followed by the Secretary's own revision of the wage index in 1986 which accounted for part-time employees, 51 Fed. Reg. 16772 (1986), and to Congress' directive that the revised index be applied to discharges occurring after May 1, 1986. Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, §9103(a), 100 Stat. 156. Second, they asserted that under the cost limits a rural

hospital could not show that it incurred the same wage costs as its urban counterparts when in fact its location next to urban hospitals forced it to compete for employees by offering equivalent compensation. Petitioners also complained that the cost limits were applied conclusively rather than presumptively. Invoking clause (ii), which provides for "suitable retroactive corrective adjustments," they argued that they were entitled to reimbursement of all costs they could show to be reasonable, even if they were in excess of the applicable cost limit. [FN4] Because the PRRB believed that it lacked the authority to award the desired relief, it granted petitioners' request for expedited judicial review. See 42 U.S.C. §1395oo(f)(1). Adhering to the Eighth Circuit's decision in *St. Paul-Ramsey Medical Center v. Bowen*, 816 F.2d 417 (1987), the District Court ruled for petitioners, holding that clause (ii) compelled the Secretary to reimburse all costs shown to be reasonable, regardless of whether they surpassed the amount calculated under the cost limit schedule. [FN5] The United States Court of Appeals for the Eighth Circuit reversed. *Good Samaritan Hospital v. Sullivan*, 952 F.2d 1017 (1991). The court relied on our decision in *Bowen v. Georgetown University Hospital*, 488 U. S. 204 (1988), in which we held that clause (ii) does not permit retroactive rulemaking. 952 F.2d, at 1023. It reasoned that petitioners' request for adjustments to correct "inequalities in the system . . . would amount to a retroactive change in the methods used to compute costs that, after *Georgetown*, is invalid." Id., at 1024. Instead, the Court of Appeals adopted the Secretary's more modest view of clause (ii) as permitting only a "year-end book balancing of the monthly installments" with the amount determined to be "reasonable" under the applicable regulations. Ibid. Under this approach, clause (ii) establishes the mechanism through which the total of the interim payments extended pursuant to §1395g (which merely purport to be estimates of actual costs) are reconciled

with the postaudit amounts determined at year's end to be owed under the methods determining allowable costs. [FN6] We granted certiorari to resolve a conflict among the Courts of Appeals. [FN7] 506 U. S. (1992).

II.

A. The starting point in interpreting a statute is its language, for "if the intent of Congress is clear, that is the end of the matter." *Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U. S. 837, 842 (1984). See also *NLRB v. Food & Commercial Workers*, 484 U. S. 112, 123 (1987). Clause (ii) instructs the Secretary to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." Petitioners argue that the mandate is clear: The methods for determining reasonable costs having been determined pursuant to §1395x(v)(1)(A), clause (ii) must be read to mean that such methods nonetheless might yield "inadequate or excessive" amounts in any particular instance. Where such is the case, it is submitted, the clause mandates a correction that will provide full reimbursement for reasonable costs. In contrast, the Secretary asserts that the "aggregate reimbursement" refers to the sum total of the interim payments made pursuant to §1395g. These payments are, of course, based on the methods chosen by the Secretary to determine reasonable costs, but they are only anticipatory estimates of what the providers' reimbursable costs will be, made before all relevant data is available. At year's end, when the provider's reimbursable costs for services actually provided during that year are on hand, the pre-audit "aggregate" of the interim payments can be compared to the postaudit amounts due under the methods. Because the interim payments might have been erroneously calculated,

their total might not match amounts owed, and adjustments must be performed to reconcile the two. See 42 C.F.R. §413.64(e), (f) (1992). In our view, the language of clause (ii) does not itself clearly settle the issue before us. The clause is ambiguous in two respects. First, the "aggregate reimbursement produced by the methods of determining costs" could mean either (in petitioners' view) the amount due given proper application of the Secretary's regulations, or (in the Secretary's) the total of the interim payments, themselves derived from application of the methods to rough, incomplete data. Second, the clause refers to "inadequate" and "excessive" reimbursements, but without at any point stating the standard against which inadequacy or excessiveness is to be measured. Petitioners contend that the implicit referent must be the reasonable costs as established by the providers, without regard to the methods; the Secretary concludes that it must be the reasonable costs as determined by the agency applying the methods. Each of the conflicting constructions is plausible but each has its difficulty. Petitioners contend that although the interim reimbursements might lead to inaccurate repayments, they are not part of the methods of determining costs to which §1395x(v)(1)(A) refers, but rather payment methods governed by §1395g. Moreover, the book-balancing role the Secretary would have us assign to clause (ii) arguably is already performed by §1395g, which mandates periodic reimbursement "prior to audit or settlement by the General Accounting Office . . . with necessary adjustments on account of previously made overpayments or underpayments." The Secretary counters that, while clause (ii) is directed at year-end adjustments and designed to ensure that providers are reimbursed their reasonable costs, §1395g addresses periodic adjustments to be made during the course of the fiscal year; §1395g thus has its own role to play and is not surplusage. [FN8] The Secretary also argues that words such as "corrective" and "adjustments" more readily

evoke the simple mathematical rectifications that she contemplates than the complex process of revisiting applicable methods and comparing the amounts paid with an ill-defined standard of "reasonable" costs that is called for by petitioners' approach. [FN9] It is true that §1395x(v)(1)(A) defines reasonable cost as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services," and petitioners contend that this is the yardstick against which reimbursements must be measured. But the statute proceeds to explain that reasonable cost "shall be determined in accordance with regulations establishing the method or methods to be used." In similar fashion, the 1972 amendments allow for the provision of "limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable." Ibid. (emphasis added). In short, aside from the implementing agency's determination pursuant to its regulations, as to which Congress granted broad discretion, there is no available standard of reasonableness that could form a ready basis for "correction" or "adjustment." [FN10]

B. Because both the parties and the Court of Appeals are of the view that *Georgetown* is controlling, we turn our attention for a moment to our decision in that case. In 1983, a District Court struck down the Secretary's 1981 new cost rule for failure to comply with notice and comment requirements. After following proper procedures, the Secretary promulgated the same rule in 1984 and sought to apply the method retroactively for the time it had been held invalid. 488 U. S., at 206-207. Drawing on the authority of clause (ii), the Secretary thus began to recoup "overpayments" claimed to have been made to hospitals as a result of the District Court's decision. The precise question we faced was whether clause (ii) permitted such retroactive

rulemaking. We held that it did not. As we explained, although clause (ii) "permits some form of retroactive action it does not provide authority for retroactive promulgation of cost-limit rules." Id., at 209. Rather, "clause (ii) directs the Secretary to establish a procedure for making case-by-case adjustment to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases. The structure and the language of the statute require the conclusion that the retroactivity provision applies only to case-by-case adjudication, not to rulemaking." Ibid. (footnote omitted). As we further stated, "nothing in clause (ii) suggests that it permits changes in the methods used to compute costs; rather, it expressly contemplates corrective adjustments to the aggregate amounts or reimbursement produced pursuant to those methods." Id., at 211 (emphasis in original). But while *Georgetown* eliminated across-the-board, retroactive rulemaking from the scope of clause (ii), it did not foreclose either of the two interpretations urged in this case: case-by-case adjustments based on a comparison of interim payments with "reasonable" costs as determined by the Secretary; and case-by-case adjustments based on a comparison of amounts due under the regulations with "reasonable" costs as demonstrated by the provider. Cf. Id., at 209, n. 1.

III.

A. Confronted with an ambiguous statutory provision, we generally will defer to a permissible interpretation espoused by the agency entrusted with its implementation. See *National Railroad Passenger Corp. v. Boston & Maine Corp.*, 503 U. S. --, -- (1992) (slip op., at) *Department of Treasury, IRS v. FLRA*, 494 U. S. 922, 933 (1990); *K mart Corp. v. Cartier, Inc.*, 486 U. S. 281, 291-292 (1988). Of particular relevance is the agency's contemporaneous construction which "we have allowed . . .

to carry the day against doubts that might exist from a reading of the bare words of a statute." *FHA v. The Darlington, Inc.*, 358 U. S. 84, 90 (1958). See also *Aluminum Co. of America v. Central Lincoln Peoples' Utility Dist.*, 467 U. S. 380, 390 (1984). In this case, the regulatory framework put in place by the agency in furtherance of the Medicare program supports the book-balancing approach to clause (ii). Nowhere in the regulations was there mention of a mechanism for implementing the kind of substantive recalculation and deviation from approved methods suggested by petitioners. On the other hand, the regulations provided on more than one occasion for the year-end book balancing adjustment that, in the Secretary's opinion, is mandated by clause (ii). For instance, 20 C.F.R. §405.451(b)(1) (1967) stated: "These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year . . . and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services rendered to beneficiaries during the year." [FN11] Use of the words "suitable retroactive adjustment," borrowed from clause (ii), demonstrates the agency's understanding. As we wrote in *Georgetown*, " it is clear from the language of these provisions that they are intended to implement the Secretary's authority under clause (ii)." 488 U. S., at 211, n. 2 (emphasis added). What is more, " these are the only regulations that expressly contemplate the making of retroactive corrective adjustments." Id., at 212 (emphasis added). From the outset, then, the agency viewed clause (ii) as a directive for retroactive adjustment of payments for allowable costs, as determined by the methods. In the aftermath of the 1972 amendments adding the cost limit provision, the agency appears to have ascribed the same role to clause (ii), namely to retroactively correct the

difference between interim payments and reasonable costs-only, as a result of the amendments, the adjustment would now be based on the new definition of reasonable costs, which includes the cost limits that as a general rule were not to be exceeded. As previously described, however, the regulations promulgated by the Secretary permitted various exceptions, exemptions, and adjustments to the limits. See 20 C.F.R. §405.460(f) (1975); supra, at -. A provider could obtain a reclassification "on the basis of evidence that its classification is at variance with the criteria specified in promulgating limits." 20 C.F.R. §405.460(f)(1) (1975). Exemptions for sole community hospitals have expanded to include new providers, rural hospitals with less than 50 beds; exceptions now extend to atypical services, circumstances such as strikes or floods, educational services, essential community services, unusual labor costs. See 42 C.F.R. §413.30 (1992). The agency's development and continued augmentation of a list of situations in which the cost limits would be waived is difficult to harmonize with an interpretation of clause (ii) that would give a provider the right to contest the application of any particular and statutorily authorized method to its own circumstances. Rather, it is consistent with a view that the cost limits by definition entailed generalizations that would benefit some providers while harming others, and with a desire to refine these approximations through the Secretary's creation of exceptions and exemptions. [FN12]

B. Petitioners argue that any deference to the agency's current position is unwarranted in light of its shifting views on the matter. It is true that over the years the agency has embraced a variety of approaches. Compare, e.g., *Regents of Univ. of California v. Heckler*, 771 F.2d 1182 (CA9 1985) (agency contends that clause (ii) permits only book-balancing); *Whitecliff v. United States*, 210 Ct. Cl. 53, 536 F.2d 347 (1976) (same), with *Georgetown*, supra

(agency argues that clause (ii) allows retroactive rulemaking). In response, the Secretary attributes such inconsistency to the lower courts' erroneous interpretations of clause (ii). If providers could obtain substantive retroactive adjustments in the event of alleged underpayment, the argument goes, then so, in the face of alleged underpayment, would the agency. However, in the aftermath of *Georgetown*, she notes that the agency returned to its earlier position. The Secretary is not estopped from changing a view she believes to have been grounded upon a mistaken legal interpretation. See *Automobile Club of Michigan v. Commissioner*, 353 U. S. 180, 180-183 (1957). Indeed, "an administrative agency is not disqualified from changing its mind; and when it does, the courts still sit in review of the administrative decision and should not approach the statutory construction issue de novo and without regard to the administrative understanding of the statutes." *NLRB v. Iron Workers*, 434 U. S. 335, 351 (1978). See also *NLRB v. Curtin Matheson Scientific, Inc.*, 494 U. S. 775, 787 (1990); *NLRB v. J. Weingarten, Inc.*, 420 U. S. 251, 265-266 (1975). On the other hand, the consistency of an agency's position is a factor in assessing the weight that position is due. As we have stated, "an agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view." *INS v. Cardoza-Fonseca*, 480 U. S. 421, 446, n. 30 (1987) (quoting *Watt v. Alaska*, 451 U. S. 259, 273 (1981)). How much weight should be given to the agency's views in such a situation, and in particular where its shifts might have resulted from intervening and possibly erroneous judicial decisions and its current position from one of our own rulings will depend on the facts of individual cases. Cf. *FEC v. Democratic Senatorial Campaign Committee*, 454 U. S. 27, 37 (1981).

C. In the circumstances of this case, where the agency's interpretation of a statute is at least as plausible as competing ones, there is little, if any, reason not to defer to its construction. We should be especially reluctant to reject the agency's current view which, as we see it, so closely fits "the design of the statute as a whole and . . . its object and policy." *Crandon v. United States*, 494 U. S. 152, 158 (1990). Section 1395 explicitly delegates to the Secretary the authority to develop regulatory methods for the estimation of reasonable costs. See 42 U.S.C. §1395x(v)(1)(A). [FN13] To be sure, by virtue of their being generalizations, they necessarily will fail to yield exact numbers-to the detriment of health care providers at times, to their benefit at others. [FN14] Presumably, the methods could use a more exact mode of calculating depreciation, cf. *Daughters of Miriam Center for the Aged v. Mathews*, 590 F.2d 1250 (CA3 1978), account for proximity to a college or university because it can distort the wage index, cf. *Austin, Texas, Brackenridge Hospital v. Heckler*, 753 F.2d 1307, 1316 (CA5 1985), or to a high-crime zone in which heightened, and expensive, security is called for. All of these variables, and many others, affect actual costs; factoring them in the methods undoubtedly would improve their accuracy. But "where, as here, the statute expressly entrusts the Secretary with the responsibility for implementing a provision by regulation, our review is limited to determining whether the regulations promulgated exceeded the Secretary's statutory authority and whether they are arbitrary and capricious." *Heckler v. Campbell*, 461 U. S. 458, 466 (1983) (footnote and citations omitted). Besides being textually defensible, the Secretary's restrictive reading of clause (ii) comports with this broad delegation of authority. Congress saw fit to empower the agency to devise methods to estimate actual costs, and the agency has opted for the use of certain generalizations, with additional fine-tuning by way of exceptions, exemptions, reclassifications, and by making

allowances for possible variations in costs consistent with efficiency. See n. , supra. [FN15] What the agency forbids is the kind of wide range, ad hoc reassessments of the accuracy of the chosen methods implicit in petitioners' interpretation. Indeed, and for all practical purposes, petitioners' contention is that the methods chosen by the agency did not take into account sufficient variables, namely the proportion of part-time workers and proximity to urban centers. It is, in all but name, a challenge to the validity of the methods-albeit in an individual case including the cost limits, the exceptions and the exemptions, and to their adequacy as gauges of reasonable costs. The Secretary has construed the statute to allow such attacks, not via clause (ii), but rather, in keeping with the broad authority with which she is possessed, by way of the arbitrary and capricious provision of the Administrative Procedure Act, 5 U.S.C. §706. [FN16]

IV.

The issue is not without its difficulties whichever way we turn. Though not the sole permissible one, the agency's interpretation of clause (ii), manifested in regulations promulgated soon after enactment and expressed today, "gives reasonable content to the statute's textual ambiguities." *Department of Treasury, IRS v. FLRA*, 494 U. S., at 933. The judgment of the Court of Appeals is Affirmed.

FOOTNOTES

FN1 Section 1395x(v)(1)(A) provides in pertinent part that the Secretary "shall" determine reasonable costs "in accordance with regulations establishing the method or methods to be used, and the items to be included, in

determining such costs for various types or classes of institutions, agencies, and services."

FN2 Regulations regarding the determination of reimbursable costs were originally codified at 20 C.F.R. Sections 405.401-405.454 (1967). They have twice been redesignated, first in 1977, at 42 C.F.R. pt. 405, see 42 Fed. Reg. 52826 (1977), and then in 1986, at 42 C.F.R. pt. 413. See 51 Fed. Reg. 34790 (1986). Unless reference to a particular date is appropriate, the 1986 designation will be used in this opinion.

FN3 Congress substantially modified the payment system by instituting the Prospective Payment System (PPS), effective October 1, 1983. Under this new system, providers are reimbursed a fixed amount for each discharge, based on the patient's diagnosis, and regardless of actual cost. See 42 U.S.C. §1395ww(d). Because the providers' claims in this litigation involve costs incurred from 1980 to 1983, PPS is not at issue. Moreover, PPS does not apply to skilled nursing facilities or home health agencies, nor does it apply to all hospitals. See 42 U.S.C. Sections 1395ww(d), (b); 42 C.F.R. Sections 412.22- 412.23 (1992).

FN4 Petitioners concede that they do not qualify for any of the exceptions or exemptions provided in the regulations. Brief for Petitioners 22, n. 19.

FN5 The court did not rule on the hospitals' claim that the wage index and rural/urban classifications were arbitrary and capricious in violation of the Administrative Procedure Act, 5 U.S.C. §706.

FN6 In addition, the Court of Appeals held that failure to account for parttime employment and for proximity to urban hospitals in the cost limits was not arbitrary and capricious,

since " both the wage index and the rural/urban distinction were based on objective data and regulations." 952 F.2d, at 1025.

FN7 Compare *Good Samaritan Hosp. v. Sullivan*, 952 F.2d 1017 (CA8 1991) (case below) (construing clause (ii) to provide merely for year-end book balancing); *Sierra Medical Center v. Sullivan*, 902 F.2d 388 (CA5 1990) (same); *Hennepin County v. Sullivan*, 280 U. S. App. D. C. 13, 883 F.2d 85 (1989) (same), cert. denied, 493 U. S. 1043 (1990); *Daughters of Miriam Center for the Aged v. Mathews*, 590 F.2d 1250 (CA3 1978) (same), with *Mt. Diablo Hospital v. Sullivan*, 963 F.2d 1175 (CA9 1992) (construing clause (ii) to require Secretary to reimburse all "reasonable costs," including those in excess of the cost limits), cert. pending, No. 92-720; *Medical Center Hospital v. Bowen*, 839 F.2d 1504 (CA11 1988) (same); *Fairfax Nursing Center, Inc. v. Califano*, 590 F.2d 1297 (CA4 1979) (same); *Springdale Convalescent Center v. Mathews*, 545 F.2d 943 (CA5 1977) (same); *Whitecliff, Inc. v. United States*, 210 Ct. Cl. 53, 536 F.2d 347 (1976) (same); *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (CA2 1973) (same).

FN8 The Secretary observes, however, that had clause (ii) not been enacted, "the authority for some similar year-end mechanism might have been inferred under the Act as a whole, including 42 U.S.C. §1395g." Brief for Respondent 27, n. 16.

FN9 Also of potential significance is Congress' reference to "aggregate reimbursement" as opposed to mere "reimbursement." "Aggregate" signifies "sum total," see Webster's Collegiate Dictionary 64 (9th ed. 1983), and its use therefore might suggest that Congress had in mind the outcome of adding up the interim payments.

FN10 While both parties invoke legislative history, in this case it is of little, if any, assistance. Petitioners point to a comment in the Committee Reports explaining that the cost limits were merely "presumptive" and that "providers would, of course, have the right to obtain reconsideration of their classification for purposes of cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception." S. Rep. No. 92-1230, pp. 188-189 (1972). As the Secretary notes, it is entirely possible that by providing for exceptions, exemptions and reclassifications, the agency satisfied this demand. Indeed, the only specific exemption mentioned in the Committee Reports - sole community hospitals - was put into effect by the agency. See Id., at 188; 42 C.F.R. §413.30(e)(1) (1992). The legislative history adduced by the Secretary is no more persuasive.

FN11 Other regulations, by comparison, appeared to be directed at the periodic preaudit adjustments to be made during the course of the year as expressly required by §1395g. See, e.g., 20 C.F.R. §405.454(e) (1967).

FN12 The agency's explanation of how it was computing cost limits in 1981 further illustrates this basic understanding: "The revised limits, like the current limits, are set at 112 percent of the mean labor-related costs and mean non-labor costs of each comparison group. The 12 percent allowance above the mean is intended to account for variations in costs that are consistent with efficiency but are not explicitly accounted for under our methodology for deriving and adjusting the limits, or by the exceptions or exemptions provided by our regulations." 46 Fed. Reg. 33639 (1981) (emphasis added). Like the exceptions and exemptions themselves, such an allowance cannot easily be reconciled with the notion that clause (ii) permits

adjustments whenever costs consistent with efficiency are unaccounted for.

FN13 Such a delegation of authority is not atypical in the context of the Social Security Act. Indeed, we noted that "Congress has 'conferred on the Secretary exceptionally broad authority to prescribe standards for applying certain sections of the Act.' "*Heckler v. Campbell*, 461 U. S. 458, 466 (1983) (quoting *Schweiker v. Gray Panthers*, 453 U. S. 34, 43 (1981)).

FN14 There is no doubt that under petitioners' expansive reading of clause (ii) nothing would prevent the Secretary from demanding reimbursement where she could show that application of the methods resulted in overpayment. For instance, the modified wage index, whose generalized retroactive application we rejected in *Georgetown*, arguably could be imposed on a hospital-by-hospital basis. Such an outcome, by undermining providers' ability to predict costs, runs counter to one of Congress' apparent motivations in authorizing cost limits. See S. Rep. No. 92-1230, at 188 (because limits on costs recognized as reasonable would be set prospectively, "the provider would know in advance the limits to Government recognition of incurred costs and have the opportunity to act to avoid having costs that are not reimbursable").

FN15 Moreover, we note that in its 1981 amendment to §1395x(v), Congress explicitly endorsed the agency's method of implementing the statute by providing that "the Secretary, in determining the amount of the payments that may be made . . . may not recognize as reasonable (in the efficient delivery of health services) routine operating costs for the provision of general inpatient hospital services by a hospital to the extent these costs exceed 108 percent of the mean of such routine operating costs per diem for hospitals,

or, in the judgment of the Secretary, such lower percentage or such comparable or lower limit as the Secretary may determine. The Secretary may provide for such exemptions and exceptions to such limitation as he deems appropriate." 42 U.S.C. §1395x(v)(1)(L)(i) (1976 ed., Supp. V), repealed, Pub. L. 97-248 §101(a)(2), 96 Stat. 335. See also H. R. Rep. No. 97-158, pp. 326-327 (1981). As remarked earlier, see n., supra, the thrust of this scheme (imposing a firm ceiling set above the mean, purportedly to account for possible inaccuracies in the methods, and allowing the Secretary to provide for appropriate waivers) is at least at some variance with the notion that a dissatisfied provider can exceed the imposed limits and invoke its own waivers for any reason the Secretary has failed to take into account.

FN16 In fact, petitioners invoked this provision below, see App. 13-14, but the Court of Appeals rejected their APA claims, and they were not renewed in this Court.

JUSTICE SOUTER, with whom JUSTICE STEVENS and JUSTICE SCALIA join, dissenting.

In the Court's view, the contrasting interpretations of clause (ii) proffered by the petitioners and the Secretary are in such equipoise that even slight deference to the Secretary is enough to tip the balance her way. As I read it, however, the language of clause (ii) plainly favors the petitioners.

The Court focuses on two portions of clause (ii). First, it says, the phrase "aggregate reimbursement produced by the methods of determining costs" may be understood, not only as the petitioners would read it, but as the Secretary does: "the total of the interim payments . . . derived from application of the methods of determining costs to rough, incomplete data." Ante, at 8. Second, the Court finds that "inadequate or excessive" may well mean, as the Secretary

suggests, inadequate or excessive as measured against "the reasonable costs as determined by the Secretary applying the methods of determining costs." Ibid. I think the language of clause (ii) precludes these readings.

Clause (ii) identifies its subject, "aggregate reimbursement," as the figure "produced by the methods of determining costs." Thus, once we know what "the methods of determining costs" are, we should be able to discover the nature of the "aggregate reimbursement" that is "produced by" those methods. Section 1395x(v)(1)(A) makes it clear that "methods" refers to the regulations implementing the statutory mandate to pay providers of services "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The first sentence of §1395x(v)(1)(A), which together with §1395hh authorizes the Secretary to issue such regulations, identifies them as "regulations establishing the . . . methods to be used . . . in determining . . . costs." And clause (i) of §1395x(v)(1)(A) uses the exact same phrase as clause (ii): the regulations shall take into account both direct and indirect costs, it says, so that "under the methods of determining costs," patients who are not Medicare beneficiaries will not subsidize beneficiaries, nor will beneficiaries subsidize nonbeneficiaries. Thus, "the methods of determining costs" are not procedures for estimating costs to make interim payments; rather, they are the means for figuring the actual "reasonable cost of . . . services."

The Secretary appears not to dispute this, but contends, in the Court's words, that the phrase "produced by the methods of determining costs" actually means "derived from application of the methods to rough, incomplete data." Ante, at 8. In other words, as the Government asserted at oral argument, "what you're really doing is taking estimated data but

running them through the same methods that you're eventually going to run the final data through in order to get a result." Tr. of Oral Arg. 31-32. There is, however, an obvious difficulty with this proposed interpretation: the complete lack of any reference to "incomplete" or "estimated" data in clause (ii). Two less obvious difficulties are even more telling.

First, nothing in Title XVIII of the Social Security Act specifies that interim payments should be calculated by applying to estimated data the complete, detailed methodology for reaching a final reasonable cost figure; the Secretary's own regulations, indeed, suggest just the opposite. "The interim payment," states the relevant regulation, "may be related to the last year's average per diem, or to charges, or to any other ready basis of approximating costs." 42 C.F.R. §413.60(a) (1992). And for purposes of devising preliminary estimates, this makes perfect sense; working through a permissible method for determining costs in all its detail may not improve the quality of an estimate if the raw figures used are mostly guesswork. But this divergence of methods for calculating interim payments and methods for determining reasonable cost casts doubt on the Secretary's proffered interpretation of "produced by the methods of determining costs." If interim, estimated payments may in fact be calculated without strict adherence to the methods of determining costs, it is hard to see why Congress would choose to identify a series of interim payments as "the aggregate reimbursement produced by the methods of determining costs."

Second, the Secretary's interpretation assumes that "the methods of determining costs" are no more than a series of equations, which can be applied as readily to final, audited cost figures as to mere projections. But the statute suggests that the term "methods" is not to be understood so narrowly.

In the words of the statute, for example, the regulations establishing the methods may not only "provide for determination of the costs of services on a per diem, per unit, per capita, or other basis"; they may also "provide for the use of estimates of costs of particular items or services." §1395x(v)(1)(A). Thus, as the statute conceives of them, the methods encompass not only a set of equations, but a set of determinations about whether to use actual costs or cost estimates for particular items or services. This set of determinations is relevant, of course, not to reckoning interim payments, but to calculating the final reimbursement due the provider of health services. Accordingly, a figure that is "produced by the methods of determining costs" should, absent some contrary indication, be the final figure.

The Court asserts that a contrary indication may be found in the use of the adjective "aggregate" to modify "reimbursement." " 'Aggregate,' " says the Court, "signifies 'sum total' and its use therefore might suggest that Congress had in mind the outcome of adding up the interim payments." Ante, at 9, n. 9 (citation omitted). I find no such suggestion in the statute's use of that term, for "aggregate," unlike, say, "cumulative," carries no necessary connotation of addition over time. More importantly, there is a far better explanation for the use of the term "aggregate." A health care provider will, over the course of a fiscal year, provide many different kinds of services to Medicare beneficiaries. Part A Medicare benefits, for example, cover, among other things, "inpatient hospital services," see 42 C.F.R. §409.5 (1992), a term that encompasses everything from bed and board, nursing services, and use of hospital facilities to medical social services, drugs, biologicals, supplies, appliances and equipment, certain other diagnostic and therapeutic services, and medical or surgical services provided by certain interns or residents-in-training. §409.10(a). The statute plainly contemplates the use of

different methods to determine the costs of these various services, see 42 U.S.C. §1395x(v)(1)(A) (stating that the regulations "may provide for using different methods in different circumstances"), and the Secretary has indeed provided for a number of different methods. For instance, under the Secretary's "departmental method" for apportioning costs, the provider's cost of "routine services" is apportioned between Medicare and non-Medicare patients on an average cost per diem basis, whereas the cost of "ancillary" services is apportioned on the basis of the ratio of Medicare beneficiary charges to total patient charges in each department. See 42 C.F.R. §413.53(a)(1) (1992). The combined reimbursement for all of the different services performed by a health care provider, as calculated under all of the different methods allowed by the statute and specified in the regulations and other materials published by the Secretary, may aptly be labeled the "aggregate reimbursement."

As I thus read the statute, the term "aggregate" is important in making it clear not only that the "reimbursement" considered in clause (ii) is the total amount received by a provider for all of the services it has rendered to Medicare beneficiaries, but that the amount received should be considered only as a whole. This focus on the total amount received means that a provider who shows that a method results in a understating of the reasonable cost of a particular service will not necessarily be entitled to a "retroactive corrective adjustment" to recover that particular cost, for the Government may be able to show that the same method, or another method used by the provider, has overstated other costs. (By the same token, of course, the Government will not always deserve an adjustment when it shows that a method has overstated a particular cost.) The text's direction to look only at the total reimbursement also means that the provider will not be entitled to the prospective application of

a more accurate method of its own devising, an insight into the statute that is hardly new; as the Court acknowledges, see ante, at 11, we recognized in *Bowen v. Georgetown University Hospital*, 488 U. S. 204, 211 (1988) (emphasis in original), that "nothing in clause (ii) suggests that it permits changes in the methods used to compute costs; rather, it expressly contemplates corrective adjustments to the aggregate amounts of reimbursement produced pursuant to those methods." This emphasis on the total, aggregate reimbursement received by the health-care provider makes sense in light of the broader goals of the Medicare program, addressing as it does Congress's concern that Medicare neither subsidize, nor be subsidized by, non-Medicare patients. See §1395x(v)(1)(A)(i). As long as the aggregate Medicare reimbursement to a health-care provider equals its total reasonable costs of providing services to Medicare beneficiaries, that goal has been attained; the details of the methods used do not matter. Thus, I can find no ambiguity in the phrase "aggregate reimbursement produced by the methods of determining costs"; it refers univocally to the total, final amount due to a provider for services rendered to Medicare beneficiaries under the regulations promulgated by the Secretary.

The Court also finds ambiguity in the direction stated in clause (ii) to provide for an adjustment if the reimbursement proves to be "inadequate or excessive." While I agree with the Court that clause (ii) does not itself "at any point state the standard against which inadequacy or excessiveness is to be measured," ante, at 8, the absence of an explicit reference to a standard in clause (ii) does not keep us from looking for other textual clues about that standard. In this case, the strongest textual clue is found in the immediate neighbor of clause (ii), clause (i). Together, clauses (i) and (ii) form the fourth and last sentence of §1395x(v)(1)(A). Whereas the third sentence of §1395x(v)(1)(A) is permissive, the fourth

sentence is mandatory; it concerns those things that the Secretary's regulations "shall" take into account or for which they "shall" provide. Clause (i) requires the regulations to take into account "both direct and indirect costs of providers of services" so that "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs." §1395x(v)(1)(A)(i). The first of these two undesired results, it will be noted, would occur if the aggregate reimbursement to the provider were inadequate, in the sense of failing to cover all reasonable costs; the second, if that reimbursement were excessive.

Clause (ii) does not contain as exhaustive a description of its goal as clause (i); it simply requires the regulations to provide for suitable corrective adjustments where the methods of determining costs produce a reimbursement that "proves to be either inadequate or excessive." §1395x(v)(1)(A)(ii). Reading the two clauses together, however, I think it most reasonable to take clause (ii)'s "inadequate or excessive" as shorthand for the two consequences that were just described in the same order, but more fully, in clause (i). This construction has the further virtue, of course, of support in my reading of the phrase "aggregate reimbursement produced by the methods of determining costs." For if that phrase, as I contend, refers to the amount ultimately due the provider as calculated under the Secretary's regulations (that is, according to the Secretary's "methods"), then the standard against which that amount is measured as "inadequate or excessive" must refer to some other figure (that is, a figure produced by some different method); no amount can be "inadequate or excessive" in relation to itself. Thus, in context, the phrase "inadequate or excessive" is not equivocal.

Broadening the context to all of Title XVIII only confirms the view that clause (ii) requires regulations providing for case-by-case exceptions to the methods for determining costs. Section 1395x(v)(1)(A), where clause (ii) is located, is a definitional, rather than an operative, provision; §1395x(v) defines "reasonable costs." The chief operative provision to which §1395x(v) relates is §1395f(b), which is titled "Amount paid to provider of services"; §1395f(b)(1) provides that under the Medicare program, providers of services are generally to be paid "the lesser of (A) the reasonable cost of such services, as determined under §1395x(v) of this title . . . or (B) the customary charges with respect to such services." "Payments to providers of services" are covered under another section, 1395g. That section requires the Secretary "periodically to determine the amount which should be paid . . . to each provider of services," and requires "the provider of services to be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) . . . the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments." §1395g(a). As the Court notes, ante, at 8, the petitioners argue that this section's provision for "necessary adjustments on account of previously made overpayments or underpayments" provides for the very book-balancing operation that the Secretary advances as the function of clause (ii), and thus renders clause (ii), as interpreted by the Secretary, entirely superfluous. The Court nonetheless appears to accept the Secretary's explanation that §1395g deals with periodic adjustments to be made during the course of the fiscal year, whereas clause (ii) is directed at year-end adjustments. Ante, at 8. Two circumstances keep me from doing the same.

First, nothing in the language of §1395g excludes "year-end adjustments" from its purview, or draws any distinction at all

between periodic and year-end adjustments. All payments to providers for services to Medicare beneficiaries are made under the authority of §1395g, since it is the only section in Title XVIII of the Social Security Act to deal with that subject; and §1395g thus authorizes all payments to be "adjusted on account of previously made overpayments or underpayments." It is doubtless this breadth which leads the Secretary to concede that had clause (ii) never been enacted, "the authority for some similar year-end mechanism might have been inferred under the Act as a whole, including 42 U.S.C. 1395g." Brief for Respondent 27, n. 16.

Second, the Secretary's proposed distinction between year-end and periodic adjustments fails to explain why Title XVIII would describe year-end, but not periodic, adjustments as "retroactive." The Secretary interprets "retroactive," as it appears in clause (ii), to mean only relating to a period for which some payment has already been made, thus rejecting the more common, stricter legal sense of the word, which implies the upsetting of some prior settled expectation or transaction. In this weak sense employed by the Secretary, however, the adjustments authorized by §1395g are just as "retroactive" as those authorized under the Secretary's interpretation of clause (ii); they too relate to "previously made overpayments or underpayments." This leaves the Secretary with no way to explain why Congress, in passing the Social Security Amendments of 1965 (which established the Medicare program, and contained both passages, see 79 Stat. 297, 323), chose to distinguish §1395g "adjustments" from §1395x(v)(1)(A)(ii) "retroactive corrective adjustments."

For all of these reasons, I believe the text of the statute unambiguously requires the promulgation of regulations allowing providers (and the Secretary) to seek adjustments on the grounds that, as calculated under the methods of

determining costs, the total reimbursement for a fiscal period is lower than (or higher than) the actual reasonable cost of providing services to Medicare beneficiaries. I respectfully dissent from the Court's opposite conclusion.

APPENDIX K

The METHODIST HOSPITAL, et al.

v.

Donna SHALALA, Secretary,
Department of Health and Human Services.

Nos. 91-5401, 91-5436, 92-5210 and 92-5248.
United States Court of Appeals, District of Columbia Circuit.

Sept. 16, 1993.
Rehearing and Suggestion for Rehearing En Banc
Denied in No. 91-5401 Nov. 16, 1993.
D.D.C., 1992 WL 280797.
REVERSED.

Before: BUCKLEY, GINSBURG, and HENDERSON, Circuit Judges.

JUDGMENT

PER CURIAM.

This appeal was considered on the record from the United States District Court for the District of Columbia and on the briefs of counsel. The court is satisfied, after reviewing the parties' briefs, that appropriate disposition of the case does not call for further opinion. See D.C. Cir. R. 14(c).

We reverse the district court's summary judgment that the adjustments provided for under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) at 42 U.S.C. §1395ww(b)(4)(A) are incorporated into §1395ww(d) for

hospitals subject to the Medicare Program's Prospective Payment System (PPS) during the four-year transition period from the TEFRA-mandated system to PPS. *Episcopal Hospital, et. al. v. Shalala*, 994 F.2d 879 (D.C. Cir. 1993) holds squarely to the contrary. Methodist Hospital's second argument in this appeal, that an award of interest should accompany any payment made to the hospitals as a result of the present litigation, is therefore moot.

ORDERED and ADJUDGED that the summary judgment from which this appeal has been taken be reversed.

The clerk is directed to withhold issuance of the mandate herein until seven days after disposition of any timely petition for rehearing. See D.C. Cir. R. 15(b)(2).

APPENDIX L

SACRED HEART MEDICAL CENTER

v.

as Secretary of Health and Human Services.

Louis W. SULLIVAN, M.D., in his official capacity Louis W. Sullivan, M.D.,
Secretary of Health & Human Services,

Appellant.

No. 91-1795.

United States Court of Appeals,
Third Circuit.

Argued Feb. 14, 1992.
Decided March 9, 1992.

Hospital brought action against the Secretary of Health and Human Services seeking judicial review of decision of the Provider Reimbursement Review Board denying Medicare reimbursement for certain inpatient operating costs hospital had incurred in connection with new facility. The United States District Court for the Eastern District of Pennsylvania, Jay C. Waldman, J., ordered Secretary to modify hospital's target rate to take into consideration operating costs hospital had incurred after its base year due to new facility, and Secretary appealed. The Court of Appeals, Greenberg, Circuit Judge, held that section of the Social Security Act enacting Prospective Payment

System (PPS) for Medicare reimbursement of health care providers does not incorporate prior provision of the Tax Equity and Fiscal Responsibility Act (TEFRA) directing the Secretary to adjust reimbursement amounts where "events beyond the hospital's control or extraordinary circumstances * * * create a distortion in the increase in costs for a cost reporting period," and thus hospital was not entitled to modification of target rate to take into consideration operating costs it incurred after its base year due to new facility.

Reversed and remanded.

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[1] FEDERAL COURTS k595
170Bk595
Because Court of Appeals is only authorized to review final judgments of district court, denials of summary judgment are ordinarily not appealable; however, when an appeal from a denial of summary judgment is raised in tandem with an appeal of an order granting a cross motion for summary judgment, Court has jurisdiction to review propriety of denial of summary judgment by the district court; in addition, where facts are uncontroverted, Court is free to enter order directing summary judgment in favor of appellant. 28 U.S.C.A. §1291.

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[1] FEDERAL COURTS k769
170Bk769
Because Court of Appeals is only authorized to review final judgments of district court, denials of summary judgment are ordinarily not appealable; however, when an appeal from a denial of summary judgment is raised in tandem with an appeal of an order granting a cross motion for summary judgment, Court has jurisdiction to review propriety of denial of summary judgment by the district court; in addition, where facts are uncontroverted, Court is free to

enter order directing summary judgment in favor of appellant. 28 U.S.C.A. §1291.

[1] FEDERAL COURTS k935.1
170Bk935.1
Formerly 170Bk935
Because Court of Appeals is only authorized to review final judgments of district court, denials of summary judgment are ordinarily not appealable; however, when an appeal from a denial of summary judgment is raised in tandem with an appeal of an order granting a cross motion for summary judgment, Court has jurisdiction to review propriety of denial of summary judgment by the district court; in addition, where facts are uncontroverted, Court is free to enter order directing summary judgment in favor of appellant. 28 U.S.C.A. §1291.

[2] STATUTES k219(3)
361k219(3)
While it is generally true that less deference should be accorded to administrative interpretations that lack consistency, agency is not locked into first interpretation it espouses; instead, agency must offer a "reasoned justification" for the change in its interpretation of statute or modification of its policy.

[3] SOCIAL SECURITY AND PUBLIC WELFARE k241.10
356Ak241.10
Section of the Social Security Act enacting Prospective Payment System (PPS) for Medicare reimbursement of health care providers does not incorporate prior provision of the Tax Equity and Fiscal Responsibility Act (TEFRA) directing the Secretary of Health and Human Services to adjust reimbursement amounts where "events beyond the hospital's control or extraordinary circumstances * * * create

a distortion in the increase in costs for a cost reporting period"; rather, the PPS contains its own provision endowing Secretary with authority to create exceptions to amount of reimbursement that would otherwise be afforded under the PPS. Social Security Act, §1886(b)(3)(A), (b)(4)(A), (d)(5), as amended, 42 U.S.C.A. §1395ww(b)(3)(A), (b)(4)(A), (d)(5).

Stuart M. Gerson, Asst. Atty. Gen., Michael M. Baylson, U.S. Atty., Anthony J. Steinmeyer, Scott R. McIntosh (argued), Attys., Appellate Staff, Civil Div., Dept. of Justice, Washington, D.C., for appellants.

Dennis M. Barry (argued), David J. Tuckfield, Vinson & Elkins, Washington, D.C., Lewis J. Hoch, Fox, Rothschild, O'Brien & Frankel, Philadelphia, Pa., for appellee.

Before GREENBERG, COWEN, and SEITZ, Circuit Judges.
OPINION OF THE COURT

GREENBERG, Circuit Judge.

I. BACKGROUND

The defendant, Louis W. Sullivan, Secretary of Health and Human Services, appeals from an order of the district court entered on July 12, 1991, compelling him "to make an appropriate retroactive adjustment to the calculation of [appellee Sacred Heart Medical Center's] hospital-specific costs and the Medicare reimbursements based thereon" in this Medicare reimbursement case. This case originated when Sacred Heart commenced an administrative proceeding against the Secretary of Health and Human Services ("HHS") before the Provider Reimbursement Review Board (the "Board") under 42 U.S.C. §1395oo(a) to recover reimbursement from HHS under the Prospective Payment

System ("PPS") for certain inpatient operating costs the Hospital had incurred. The Board determined that Sacred Heart was not entitled to reimbursement, a decision the Administrator of the Health Care Financing Administration ("HCFA") declined to review.

Sacred Heart then sought judicial review of the Board's decision in the United States District Court for the Eastern District of Pennsylvania, which exercised jurisdiction pursuant to 42 U.S.C. §1395oo(f). The parties filed cross- motions for summary judgment, and on July 11, 1991, the district court issued a memorandum opinion determining that Sacred Heart was entitled to the reimbursement it requested. The Secretary filed a timely notice of appeal and we have jurisdiction to review the district court's final order under 28 U.S.C. §1291.

II. FACTS AND PROCEDURAL HISTORY

The facts of this case are not in dispute. Sacred Heart is a 236-bed, non- profit hospital located in Chester, Pennsylvania, said to be an "economically distressed area with the highest percentage of people in public housing in the [United States.]" Sacred Heart opened its facilities to the public in 1959, but undertook no new construction until the 1980's. As a result, the Pennsylvania Department of Health cited the Hospital for code violations and licensure deficiencies and, in addition, the Health Systems Agency of Southeastern Pennsylvania ("HSA"), the local health planning agency, and the Joint Commission on Accreditation of Hospitals, noted numerous "deficiencies" related to the Hospital's physical plant.[10]

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10 For example, Sacred Heart still operated a number of wards or rooms with four beds.

To remedy this problem, the Hospital submitted a letter of intent to the HSA proposing an expansion of its facilities. The HSA accepted this proposal, and recommended to the Pennsylvania Department of Health that Sacred Heart be expanded. That department, in turn, approved the expansion and recommended to HHS that Sacred Heart's construction-related expenditures be reimbursed. HHS accepted this recommendation, and approved the project. Although the construction was scheduled to be completed in August 1982, it was not actually completed until June 1983 due to construction problems, delays in financing, problems with a concrete sub-contractor, delays in the delivery of cabinetry, and a carpenter's strike.

In the expansion a free-standing building was constructed and connected to the existing facility. This new building houses the Hospital's intensive care unit, one floor of patient rooms, an area for maintenance equipment, the lobby, the admissions area, the emergency room, the laboratory, the radiology department, the physical therapy department and a nuclear medicine unit. Sacred Heart hired 19 nurses to cover the new facilities. This expansion is the focus of the appeal, for Sacred Heart claims that it is entitled to be compensated for its increased operating costs resulting from the expansion, while the Secretary claims that the relevant federal statute and implementing regulations do not require the government to reimburse the Hospital for these costs.

(A) The Medicare Program:

1. "Reasonable Cost" Reimbursement:

Part A of the Medicare Program, codified at 42 U.S.C. §1395c et seq. of the Social Security Act ("SSA"), provides the elderly and the disabled with "basic protection against the costs of hospital, related post-hospital, home health services, and hospice care...." 42 U.S.C. §1395c. Hospitals and other health care providers participating in the Medicare Program generally cannot collect payment for these health services from the Medicare beneficiaries themselves, but must instead obtain reimbursement from HHS in the manner set forth in the Medicare Program.

From 1966 to 1982, the Medicare Program reimbursed hospitals and other health care providers for the "reasonable cost" of covered services, which was defined as the "cost actually incurred" exclusive of costs "found to be unnecessary in the efficient delivery of needed health services." Section 1395x(v). Necessary costs included operating costs, which often increased from year to year. Under this regime, hospitals and other health care providers had little incentive to curb operating costs and render services more economically, for the federal government bore the financial burden of the increases.[11]

In 1982, Congress determined that the Medicare Program should be modified to provide hospitals with better incentives to render services more economically. Accordingly, in the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") Congress amended the SSA by imposing

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[11] Section 223 of the Social Security Amendments of 1972 imposed some limits on reimbursement for operating costs. See Pub.L. No. 92-603, §223, reprinted in 1972 U.S.C.C.A.N. 1548, 1627.

a ceiling on the rate of increase of inpatient operating costs recoverable by a hospital.[12]

Under TEFRA, the rate-of-increase limit was computed according to a hospital's "target amount" which, in turn, was calculated according to a hospital's cost reporting or "base" period. The statute provided: " 'target amount' means with respect to a hospital for a particular 12-month cost reporting period ---(i) in the case of the first reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services ... recognized ... for such hospital for the preceding 12-month cost reporting period." Section 1395ww(b)(3)(A). For each reporting period subsequent to the initial period, the target amount was increased by a specified percentage. Section 1395ww(b)(3)(A). Under this system, hospitals were obligated to absorb operating costs in excess of their target amounts, but they received bonuses if their operating costs were less than their targeted amounts. Section 1395ww(b)(1)(A).

TEFRA additionally set forth specific exceptions and adjustments applicable to the rate-of-increase limits. For example, and of great significance here, §1395ww(b)(4)(A) directed the Secretary to "provide for an exemption from, or an exception and adjustment to, the [rate-of-increase] method ... where events beyond the hospital's control or extraordinary circumstances ... create a distortion in the increase in costs for a cost reporting period...." (emphasis supplied). Accordingly, the HCFA[13] promulgated

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12 TEFRA did not impose a ceiling on the rate of increase of capital costs, which continued to be reimbursed on a reasonable-cost basis. Sections 1395ww(b)(1), 1395ww(a)(4).

13 The Secretary delegated his duties with respect to the Medicare Program to the HCFA. The HCFA, in turn, has delegated much of the

regulations permitting hospitals to modify their target amounts where they have incurred costs "due to extraordinary circumstances" or where "factors ... could result in a significant distortion in the operating costs of inpatient hospital services." 42 C.F.R. §405.463(g)(2) and (h), redesignated 42 C.F.R. §§413.40(g)(2) and (h). In addition, §1395ww(b)(4)(A) authorized the Secretary to "provide for such ... other exemptions from, and exceptions and adjustments to, [the rate-of-increase] method as the Secretary deems appropriate...."

2. Prospective Payment System:

In 1983 Congress again amended the SSA, replacing the newly-instituted TEFRA system with the PPS. The purpose of the new prospective system, which constituted a far more radical reform of inpatient operating cost reimbursement than did TEFRA, was "to reform the financial incentives hospitals face, promoting efficiency ... by rewarding cost/effective hospital practices." H.R.Rep. No. 25, 98th Cong., 1st Sess. 132 (1983), reprinted in 1983 U.S.C.C.A.N. 143, 219, 351. Under this system, which remains in effect, hospitals and other health care providers are reimbursed on the basis of prospectively determined national and regional rates rather than reasonable operating costs. This system classifies all Medicare patients into one of approximately 470 "diagnosis-related-groups" ("DRGs") and establishes fixed rates for each DRG.[14] When a hospital's actual operating costs exceed its federally

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day-to- day management of the Program to fiscal intermediaries, which are private insurance companies that act as contractors to the Medicare Program. 42 U.S.C. §1395h.

14 The federal rate is based on national averages, but is adjusted for local wages. 42 U.S.C. §1395ww(d)(2).

prescribed limit for the given DRG, the hospital must absorb the difference. Conversely, if a hospital's costs are lower than the federal rates, the hospital retains the difference.

While Congress was anxious to restrain costs, it recognized that a sudden break from the "reasonable cost" method of reimbursement could pose financial hardship for many health care providers. Thus, "to minimize disruption that might otherwise occur because of sudden changes in reimbursement levels," Congress established a three-year transition period between the TEFRA system and the PPS system, and later extended this transition period for an additional year. S.Rep. No. 23, 98th Cong., 1st Sess. 53 (1983), reprinted in 1983 U.S.C.C.A.N. 143, 193.

The statutory provisions in effect during the transition period required the federal government to reimburse hospitals for inpatient hospital services according to a "blended" rate, which consisted of two elements. The first element of this rate, the hospital-specific portion ("HSP"), was a specified percentage of "the hospital's target amount for the cost reporting period." Section 1395ww(d)(1)(A)(i)-(ii). The statute further provided that the hospital's "target amount" would be calculated in the manner set forth in TEFRA.[15] The second element of the blend was the federally prescribed rate.

During the first transition year under the PPS, the HSP comprised 75% of the blend, while the prospective rate equaled 25%. During the second year, the HSP was reduced to 50% of the rate, and the prospective rate equaled 50%. In

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15 Section 1395ww(d)(1)(A)(i)(I) directs the Secretary to use "the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A) of this section....)" (emphasis supplied).

the third year, the HSP was 45% while the prospective rate was 55%. In the last year, the HSP was 25% and the prospective rate was 75%. After the transition period, the PPS required the government to reimburse hospitals solely on the basis of the prospective federal rate.

Section 1395ww(d)(5) sets forth various exceptions to the reimbursement rates prescribed under the PPS.[16] In addition, this section endows the Secretary with general authority to "provide by regulation for such ... exceptions and adjustments to ... payment amounts under this subsection as the Secretary deems appropriate." 42 U.S.C. §1395ww(d)(5)(I). But §1395ww(d) contains no provision like that in 1395ww(b)(4)(A), which directed the Secretary to adjust reimbursement amounts where "events beyond the hospital's control or extraordinary circumstances ... create a distortion in the increase in costs for a cost reporting period." Accordingly, the HCFA has not promulgated any regulation permitting hospitals to be reimbursed for an increase in operating costs due to extraordinary circumstances that took place after the hospital's base year.

(B) The Dispute:

As we have already described, Sacred Heart completed construction of an additional facility to retain its hospital license and its accreditation in June of 1983. Sacred Heart operates on a fiscal year that ends on June 30. Under §1395ww(b)(3)(A), which set forth the procedure for calculating a hospital's target amount for inpatient operating costs, Sacred Heart's base year was fiscal 1983. By June 30,

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16 None of these exceptions authorizes an intermediary to adjust a hospital's HSP for extraordinary circumstances. See §1395ww(d)(5)(A)-(H).

1983, however, Sacred Heart had only utilized the new facility for two weeks and had not incurred substantial operating costs in that brief period.

On June 26, 1984, Aetna Life Insurance Company, Sacred Heart's fiscal intermediary, issued to Sacred Heart its Notice of Base Period Costs and Target Amount for Sacred Heart's first year under the PPS. Although the Intermediary included in this calculation operating costs incurred by the Hospital during the two weeks the new facility was used, it did not include any operating costs incurred after the 12-month base period.

On September 21, 1984, Sacred Heart asked the Intermediary to increase its HSP to reflect the additional operating costs associated with the new facility. The Intermediary consulted with the HCFA which, relying on the fact that the PPS did not expressly permit retroactive revision of the target amount based on changes that took place subsequent to a hospital's base year, determined that the increase could not be allowed. Further, the HCFA concluded that none of its regulations allowed for the increase requested. On December 2, 1985, the Intermediary informed Sacred Heart of HCFA's decision.[17]

(C) The Administrative Hearing:

On October 10, 1986, Sacred Heart appealed the Intermediary's decision to the Board, an administrative body charged with reviewing contested reimbursement determinations by fiscal intermediaries. Section 1395oo(a).

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17 The Secretary does not dispute that the HCFA could exercise its authority to promulgate an "extraordinary circumstances" exception to a hospital's HSP or its target rate.

In that appeal, Sacred Heart again requested that its HSP be adjusted to reflect the increased operating costs it incurred after its base year due to the new facility.[18]

On August 1, 1989, the Board determined that neither the governing statute nor the HCFA's regulations permitted the Intermediary to adjust Sacred Heart's HSP to include operating costs it incurred after its base year. On September 5, 1989, the Administrator of HCFA, sua sponte, declined to review the Board's decision.

(D) The District Court Proceeding:

On September 28, 1989, Sacred Heart commenced this action against the Secretary seeking judicial review of the Board's decision.[19] Sacred Heart contended that the "extraordinary circumstances" provision set forth in §1395ww(b)(4)(A) retained vitality after the passage of the PPS, while the Secretary urged that, because the PPS did not explicitly refer to that provision, this omission evinced a congressional intent to abandon it. Although the district court conceded that the statute and the regulations implementing it "do not expressly provide for the sort of adjustment which plaintiff seeks," it held that:

By electing to maintain during the transition period the method for computing allowable costs under the former system, Congress signaled its intent to incorporate the provisions of the former system that give it the flexibility

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18 Sacred Heart noted that, "[t]he total amount of increased costs directly attributable to the building expansion are $1,185,271."

19 Sacred Heart filed two additional complaints covering later transition years but the complaints were consolidated and as a matter of convenience we refer to all three as a single action.

that was its hallmark. Congress 'clearly signaled an intent to keep certain elements of the former system in place at least temporarily--elements that would in the end be abandoned altogether, but which were nevertheless included in order to minimize financial disruptions.' App. at 23 (quoting *Georgetown University Hospital v. Bowen*, 862 F.2d 323, 327 (D.C. Cir. 1988)).

Accordingly, it ordered the Secretary to modify Sacred Heart's target rate to take into consideration operating costs Sacred Heart had incurred after its base year due to the new facility. This appeal followed.

III. DISCUSSION

A. THE PARTIES' CONTENTIONS:

This case involves a question of statutory interpretation. Sacred Heart asserts that, although §1395ww(d) does not indicate that a hospital's target amount, as determined under §1395ww(b)(3)(A), must be modified pursuant to §1395ww(b)(4)(A), there are four indications that Congress intended such a modification. First, Sacred Heart states that §1395ww(b)(4)(A) must be read in conjunction with §1395ww(b)(3)(A) to insure that the hospital's "target amount" is calculated properly. Second, Sacred Heart contends that the legislative history of the PPS supports its view that the PPS incorporates §1395ww(b)(4)(A), since "Congress created the four-year PPS transition period to 'soften the blow' to hospitals that would have been harmed by an immediate transition to the PPS.... Congressional intent to 'soften the blow' was important because it shows that Congress would keep as much of the old system as feasible." Third, Sacred Heart notes that the HCFA had previously construed the PPS as encompassing §1395ww(b)(4)(A). Fourth, Sacred Heart

contends that the relevant caselaw concerning this issue supports its assertion that Congress intended to incorporate §1395ww(b)(4)(A) into the PPS reimbursement scheme.

In addition, it is Sacred Heart's view that, even if the Secretary's interpretation of the statute is correct, Sacred Heart "still should prevail since the agency's failure to grant relief to Sacred Heart when it has granted relief to hospitals in indistinguishable circumstances is capricious, by definition, and would be an impermissible abuse of discretion."

The Secretary's response is straightforward. He contends that the plain meaning of the statute clearly indicates that a hospital's target rate need not be adjusted for "extraordinary circumstances" because the PPS contains no reference to §1395ww(b)(4)(A), although it does refer to §1395ww(b)(3)(A). In the Secretary's view, if Congress had intended to incorporate §1395ww(b)(4)(A) into the PPS, it would have so specified. The Secretary further argues that, even if the congressional intent on this issue were ambiguous, we must defer to HCFA's statutory interpretation as it is charged with administering the Medicare Program. Because the HCFA's interpretation is reasonable, this Court cannot substitute a different, though arguably reasonable, reading of the statute.

B. STANDARD OF REVIEW:

On review of the district court's grant of summary judgment, "[t]he appellate court is required to apply the same test the district court should have utilized initially." *Goodman v. Mead Johnson & Co.*, 534 F.2d 566, 573 (3d Cir. 1976), *cert. denied*, 429 U.S. 1038, 97 S.Ct. 732, 50 L.Ed.2d 748 (1977). See *Tiernan v. Devoe*, 923 F.2d 1024, 1032 (3d Cir. 1991). Because we are only authorized to

review final judgments of the district court, 28 U.S.C. §1291, denials of summary judgment are ordinarily not appealable. *Chinchello v. Fenton*, 805 F.2d 126, 129 (3d Cir. 1986). However, when an appeal from a denial of summary judgment is raised in tandem with an appeal of an order granting a cross-motion for summary judgment, we have jurisdiction to review the propriety of the denial of summary judgment by the district court. *Nazay v. Miller*, 949 F.2d 1323, 1328 (3d Cir. 1991); *Beck v. Reliance Steel Products Co.*, 860 F.2d 576, 581 (3d Cir. 1988); *First National Bank v. Lincoln National Life Insurance Co.*, 824 F.2d 277, 281 (3d Cir. 1987). In addition, where, as here, the facts are uncontroverted, we are free to enter an order directing summary judgment in favor of the appellant. *Nazay*, 949 F.2d at 1328; *First National*, 824 F.2d at 281.

The Supreme Court in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984), set forth the standards of judicial review of an agency's construction of the statute which it administers. It noted that a court, in this situation, is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute. Id. at 842-43, 104 S.Ct. at 2781-82 (footnotes omitted).

The Court further indicated that the reviewing court "need not conclude that the agency construction was the only one it permissibly could have adopted to uphold the construction, or even the reading the court would have reached if the question initially had arisen in a judicial proceeding." Id. at 843 n. 11, 104 S.Ct. at 2782 n. 11. Moreover, the Court observed that, when Congress expressly delegates authority to an administrative body to fill in the gaps of a given statute, the regulations "are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." Id. at 844, 104 S.Ct. at 2782 (footnote omitted). Accord, *Markowitz v. Northeast Land Co.*, 906 F.2d 100, 105 (3d Cir. 1990).[20]

Sacred Heart, citing *Morton v. Ruiz*, 415 U.S. 199, 237, 94 S.Ct. 1055, 1075, 39 L.Ed.2d 270 (1974), asserts that the HCFA's interpretation of the statute is not entitled to deference because the HCFA has not consistently endorsed the interpretation it espouses here.[21] It notes that the agency has made at least two statements in the Federal Register indicating that it believed that "extraordinary circumstances" modifications were permissible under the PPS, and observes that the agency has granted the relief Sacred Heart requests in this case to other hospitals based on similar facts. Finally, Sacred Heart contends that this Court has indicated that it

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20 In addition, section 1395oo(f) of the Medicare Program provides that the standard of judicial review set forth in 5 U.S.C. s 706 of the Administrative Procedure Act must apply. That provision makes clear that a reviewing court must defer to an agency's construction of the statute it administers.

21 In Morton, the Supreme Court held that, "[t]he weight of an administrative interpretation will depend, among other things, upon 'its consistency with earlier and later pronouncements' of an agency." 415 U.S. at 237, 94 S.Ct. at 1075 (quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 140, 65 S.Ct. 161, 164, 89 L.Ed. 124 (1944)).

will "not accept a revision in administrative interpretation when it 'flatly contradicts the position which the agency had enunciated at an earlier date, closer to the enactment of the governing statute.' " *Mazza v. Secretary of Health and Human Services*, 903 F.2d 953, 959 (3d Cir. 1990) (quoting *General Electric Co. v. Gilbert*, 429 U.S. 125, 142, 97 S.Ct. 401, 411, 50 L.Ed.2d 343 (1976)).[22]

We are not persuaded by Sacred Heart's attempts to dodge the standard of review. While it is generally true that less deference should be accorded to administrative interpretations that lack consistency, an agency is not locked into the first interpretation it espouses. Instead, the agency must offer a "reasoned justification" for the change in its interpretation of a statute or a modification of its policy. See Mazza v. Secretary of Health and Human Services, 903 F.2d at 959.

Here, the Secretary contends that, although the HCFA may have previously interpreted the statute improperly, its current construction is in full accord with the language of the PPS and the legislative intent that motivated its enactment. This surely constitutes a "reasoned justification" for the Secretary's departure from its prior interpretation. Accordingly, the Secretary's interpretation of the statute must

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22 In Mazza, a claimant who filed concurrent claims for SSI and disability benefits appealed from the decision of the Appeals Council which held that claimant's disability benefits could be offset against his potential SSI benefits, although this would result in a denial of claimant's SSI benefits and his accompanying entitlement to Medicaid. We held that the Social Security Administration's unguided, random processing of concurrent claims for disability and SSI benefits, resulting in a calculation of disability benefits first, but which offset disability benefits against potential SSI benefits so that the claimant was not entitled to SSI benefits and Medicaid, was not entitled to a deferential standard of review.

be upheld if this Court determines that it is reasonable. Moreover, the HCFA's regulations implementing the authority delegated to it by the Secretary cannot be disturbed unless they are arbitrary and capricious.[23]

C. PLAIN MEANING:

As we recently stated in *Velis v. Kardanis*, 949 F.2d 78, 81 (3d Cir. 1991), "[i]t is axiomatic that statutory interpretation properly begins with the language of the statute itself, including all of its parts. There is no need to resort to legislative history unless the statutory language is ambiguous." Thus, we initially look to the statute for our result.

Section 1395ww(d) provides for reimbursement to a hospital for its inpatient operating costs according to a combination of the hospital's HSP rate and its DRG rate. Section 1395ww(d)(1)(A)(i)(I) further provides that a hospital's HSP or target rate will be calculated in the manner set forth in §1395ww(b)(3)(A). Section 1395ww(b)(3)(A), in turn, provides: Except as provided in subparagraphs (C), (D), and (E) ... 'target amount' means, with respect to a hospital for a particular 12-month cost reporting period-- (i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for such hospital for the preceding 12-month cost reporting period,

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23 Thus, the facts in this case are quite unlike those at issue in *Mazza*, where the Secretary had "not articulated any reason for changing [its] earlier practice," 903 F.2d at 959, and indeed had contended that "when processing concurrent applications he may freely apply the setoffs in a haphazard fashion." Id. at 958. We elaborate below on the reasonableness of the HCFA's interpretation.

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period. Significantly, §1395ww(b)(3)(A) does not expressly refer to §1395ww(b)(4)(A), which constitutes an exception to the target amount method set forth in §1395ww(b)(3)(A). The exception states: The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the increase in costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services....

In addition, §1395ww(d) does not refer to §1395ww(b)(4)(A). Rather, §1395ww(d)(5) sets forth its own exceptions to the amount a hospital may be reimbursed for its inpatient operating costs under the PPS. See §1395ww(d)(5)(A)-(H). That section does not include a provision for an upward modification of a hospital's target rate in the event of "extraordinary circumstances."[24]

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24 Although *Sacred Heart* relies on our opinion in *Malloy v. Eichler*, 860 F.2d 1179 (3d Cir. 1988), that case is inapposite. There, we rejected the Secretary's argument that Congress implicitly intended to amend a certain provision in the Medicaid Program because it amended a certain provision in the Aid to Families with Dependent Children ("AFDC") program. We stated, "if Congress chose explicitly to amend the AFDC requirements, the appropriate inference is that it chose to amend only those, not others.... We must assume that Congress was aware of [the Medicaid provision] when it enacted the AFDC

Moreover, §1395ww(d)(5)(I), like §1395ww (b)(4)(A), endows the Secretary with authority to "provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate."[25] Accordingly, the HCFA has promulgated regulations in the exercise of the power delegated to it by the Secretary; these regulations are codified at 42 C.F.R. §§412.71 and 412.72. Section 412.71 provides that a hospital's base year costs can be modified to include malpractice insurance, certain medical services, and FICA taxes. Plainly, none of these provisions provides a basis to modify Sacred Heart's operating costs. Section 412.72 sets forth four bases for an intermediary to modify a hospital's base-year costs to include additional costs: "inadvertent omissions," "correction of mathematical errors of calculations," "recognition of additional costs," and "successful appeal." Although §412.72(a)(3), entitled

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amendments ... but chose not to repeal or amend it." Id. at 1185. Here, in contrast, Congress abandoned the "reasonable cost" system and replaced it with the PPS, an entirely different system. Although Congress chose to enact an interim program to smooth the transition to the PPS, the reasonable cost system did not retain vitality after the passage of the PPS other than to the extent Congress designated.

25 Indeed, although the wording of this general provision differs slightly from its predecessor, §1395ww(b)(4)(A), they both endow the Secretary with authority to prescribe exceptions from the amount that would be awarded under the relevant reimbursement schemes. *Sacred Heart* argues that "[e]xceptions to payment is a different and broader proposition than exceptions to the HSP method.... No longer is the Secretary merely allowed to adjust the method for determining the target amount, but he can also adjust any part of the payment determination." This argument is unavailing. If the Secretary can make modifications to the "payments" prescribed under the PPS, which power is arguably broader than the power to make modifications to the method of payment, then there is no need to incorporate this provision of §1395ww(b)(4)(A).

"recognition of additional costs," provides the most superficially appealing means to modify the Hospital's base-year figure, that section merely permits modification of a hospital's base-year figure to include allowable costs. Costs incurred by a hospital after its base year are not allowable.[26]

Thus, the plain language of the statute and the regulations implementing it support the Secretary's view that the PPS does not include an "emergency circumstances" caveat.[27]

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26 Section 412.72(a)(3) states: (i) The Intermediary may adjust base-period costs to take into account additional costs recognized as allowable costs for the hospital's base year as the result of any of the following: (A) A reopening and revision of the hospital's base-year notice of amount of program reimbursement under §§405.1885 through 405.1889 of this chapter. (B) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under §405.1821 or §405.1853 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement. (Emphasis supplied). Subsections (C) and (D) which follow further permit a modification of the base-year figure upon action by the Board or an administrative or judicial decision. These regulations similarly do not permit Sacred Heart to receive a modification of its base-year figure because of costs incurred after its base year.

27 Sacred Heart also argues that, because §1395ww(d) provides that a hospital's target rate is defined under §1395ww(b)(3)(A) "without the application of subsection (a) of this section," its failure to specifically exclude §1395ww(b)(4)(A) evinces Congress' intent to retain that provision. However, as the Secretary notes, this argument is without merit because subsection (a) must be read in conjunction with §1395ww(b)(3)(A) because it defines one of the relevant terms of the latter provision, namely "allowable costs." Section 1395ww(b)(4)(A) does not define a relevant term contained in §1395ww(b)(3)(A); rather, it constitutes an exception to the method set forth in that provision. As the Secretary notes, "[s]ection 1886(b)(4)(A) does not affect the definition of 'target amount' " Thus, it is unnecessary to read §1395ww(b)(4)(A) in conjunction with §1395ww(b)(3)(A).

D. LEGISLATIVE HISTORY:[28]

Although the legislative history is barren of commentary directly revealing Congress' intent concerning the incorporation of §1395ww(b)(4)(A) into the PPS, the legislative history does indicate that Congress enacted the PPS to move away from the retrospective reimbursement system and replace it with a prospective system with fixed national rates.[29] This intent supports the view that an increase in a given hospital's actual operating costs should not be considered unless the statute or the regulations expressly so provide.[30]

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28 Because the statutory language is plain, there is no need to resort to the legislative history. See *Velis v. Kardanis*, 949 F.2d at 81. However, inasmuch as the district court relied upon the legislative history in determining that the PPS incorporated §1395ww(b)(4)(A), we examine it.

29 See, e.g., H.R.Rep. No. 25, 98th Cong., 1st Sess. 132 (1983), reprinted in 1983 U.S.C.C.A.N. 219, 351; S.Rep. No. 23, 98th Cong., 1st Sess. 47 (1983), reprinted in 1983 U.S.C.C.A.N. 143, 187.

30 The Secretary notes that the House Committee on Ways and Means commented that: "[t]he portion of a hospital's payment determined on its own cost base [during the PPS transition period] would be calculated as though the hospital's target amount under the 1982 TEFRA legislation were its payment amount (that is, ... without regard to the exceptions, exemptions and adjustments which may have been authorized under TEFRA for that year.)" H.R.Rep. No. 25, 98th Cong., 1st Sess. 136 (1983), reprinted in 1983 U.S.C.C.A.N. 219, 355. However, *Sacred Heart* points out that the Senate rejected the proposal to exclude all exceptions authorized under TEFRA. Further, the Conference Report indicates that the "no exceptions" provision was deleted: The conference agreement follows the Senate amendment. The managers note that during the phase-in period, some portion of the prospective payment rate will be related to each hospital's own experience in a base cost reporting year. The managers recognize that, in some cases, the Secretary will have to use estimates to adjust some

Second, although Congress created the transition period to "soften the blow" to hospitals that would have been injured by an immediate transition to the PPS system, this does not signify, as Sacred Heart asserts, that Congress intended to "keep as much of the old system as feasible." Indeed, such a view is completely insupportable, since Congress enacted the PPS precisely to avoid the problems associated with the old reimbursement regime.[31]

E. THE SECRETARY'S PRIOR INTERPRETATION OF THE STATUTE:

Sacred Heart additionally relies on the HCFA's prior interpretations of the PPS to support its contention that Congress intended to incorporate §1395ww(b)(4)(A) into the PPS. It notes that the HCFA stated in the preamble to the final PPS regulations: We believe the Congress intended to assure, by giving us broad authority under the law to provide for exceptions, exclusions, and adjustments, that some hospitals are not advantaged or disadvantaged by unique

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portions of the hospital's base year experience to make it comparable to inpatient operating costs that will be paid under the prospective system--e.g., FICA taxes that would have been paid if the hospital had been in the social security system or the adjustment needed to exclude the nursing differential which is no longer payable. H.R.Conf.Rep. No. 47, 98th Cong. 1st Sess. 181-82 (1983), reprinted in 1983 U.S.C.C.A.N. 404, 471-72. These comments do not clearly weigh in favor of either party. They do not, as the Secretary asserts, establish that Congress did not wish to retain any of the exceptions to a hospital's target rate under TEFRA, as the Conference Report expressly rejected that proposal. Nor do the statements indicate that Congress intended to retain the "exceptional circumstances" provision, since that exception is not referred to in the Conference Report.

31 Moreover, if Congress had desired, it could have retained the old system in toto.

circumstances in their base year that do not reflect their usual cost of operation per case. This intent is indicated in §1886(b)(4)(A) of the Act. 49 Fed.Reg. 261 (Jan. 3, 1984).

According to *Sacred Heart*, because the HCFA espoused this interpretation just after the statute was enacted, it is entitled to greater weight than its present interpretation.[32]

Further, Sacred Heart asserts that the HCFA proposed to revise §412.72 so that the regulation would specifically permit it to consider operating costs incurred by the hospital after the hospital's base year. Sacred Heart argues that, in proposing this revision, the HCFA stated that its then-current policy was to consider these additional costs: Our current policy is to revise the hospital-specific portion of the prospective payment rate to take into account exceptions, exemptions and adjustments granted under §§405.460 and 405.463 to the extent that they apply to base year costs.... Under current operating procedures, it is the onset of the event that caused the distortion that dictates which period's costs are adjusted. Thus, if a cost distorting event occurs in the base year, operating costs in the base year (for purposes of application of the rate-of-increase ceiling) are adjusted. 51 Fed.Reg. 8208, 8210 (Mar. 10, 1986).

The Secretary responds that, although the HCFA originally cited §1395ww(b)(4)(A) as a source of authority

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32 *Sacred Heart* cites *Udall v. Tallman*, 380 U.S. 1, 16, 85 S.Ct. 792, 801, 13 L.Ed.2d 616 (1965), where the Court noted, "[p]articularly is [judicial] respect due when the administrative practice at stake involves a contemporaneous construction of a statute by the [people] charged with the responsibility of setting its machinery in motion...." (quoting *Power Reactor Development Co. v. International Union of Electrical, etc.*, 367 U.S. 396, 408, 81 S.Ct. 1529, 1535, 81 S.Ct. 1529 (1961)).

for adjusting base-period costs during the PPS transition period, the HCFA later abandoned this reference in a subsequent Federal Register. In its later statement, the HCFA explained that its regulations were promulgated "in accordance with §1886(d)(5)(C)(iii)," the provision endowing the Secretary with discretionary authority to provide for exceptions and exemptions to the PPS reimbursement amount. Further, the Secretary notes that the HCFA's March 10, 1986, statements, indicating that the agency's practice was to modify a hospital's target amount, concerned only changes that took place during the hospital's base year. The Secretary argues that "the HCFA made clear[ ] [that] '[e]xceptions, exemptions, or adjustments granted for periods subsequent to the base year do not change the hospital-specific portion of the prospective payment rate since neither base year costs nor the target amount is altered by such action.' " (quoting 51 Fed.Reg. 8208, 8210).

The Secretary's position has greater force. The HCFA should not be bound by its previous interpretation of the PPS, though espoused shortly after the statute was enacted, where the agency modified its interpretation upon a more thorough examination of the statute.[33] In addition,

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[33] This same logic holds true with respect to Sacred Heart's argument that, even if the Secretary's construction of the statute is correct, the government should reimburse Sacred Heart for its increased operating costs incurred after its base year because it has done so for other hospitals. To withhold relief, Sacred Heart asserts, is "capricious by definition." As the Secretary correctly notes, "[n]o rule of administrative law requires the Secretary to extend the same erroneous treatment to Sacred Heart and other hospitals, thereby turning an isolated error into a uniform misapplication of the law." The Secretary's conduct cannot be deemed arbitrary and capricious when it is based upon a reasonable interpretation of the statute he is charged with enforcing. Sacred Heart additionally contends that, to the extent that regulation 405.474(b)(2)(i) permits an intermediary to exclude one-time, non-recurring costs from a hospital's target rate, but does not permit the intermediary to increase a

when the HCFA's comments cited by Sacred Heart are read in context, it appears that the HCFA's practice was to permit modifications *549 of a hospital's target rate for increases in operating costs incurred during the hospital's base year, not after it.

F. JURISPRUDENCE:

Notwithstanding our conclusion that the result in this case is clear we do observe that it appears that every court that has directly considered the issue has determined that Congress intended to incorporate §1395ww(b)(4)(A) into the PPS. For example, in *Newport Hospital and Clinic, Inc. v. Sullivan*, No. 88-2490-LFO, 1990 WL 179953, at *7 (D.D.C. Sept. 24, 1990), the Secretary advanced the same argument it does here, but the court rejected it, concluding: Subsection (b)(3)(A) defines 'target amount' as the allowable costs as set forth in yet another subsection. Subsection (b)(4)(A) establishes exceptions to subsection (b), including (b)(3)(A). For this reason, subsection (b)(3)(A) cannot be cleanly extracted from its statutory environment even if Congress

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hospital's target rate in the converse scenario, it is one- sided and unfair. It further observes that, in the preamble to the final regulations, the HCFA indicated that, "Congress intended to assure, by giving us broad authority under the law to provide for exceptions, exclusion and adjustments, that some hospitals are not advantaged or disadvantaged by unique circumstances in their base year." 49 Fed.Reg. 261 (January 3, 1984). Sacred Heart asserts that the one-sided nature of the regulation conflicts with the HCFA's own stated purpose of the regulations. However, the regulation at issue is not one-sided. Rather, it permits an intermediary to modify a hospital's target rate upwards to take into account revenue offsets. More importantly, the HCFA has broad authority to prescribe regulations governing the Medicare Program within the framework of the statutory provisions. The statute does not require the HCFA to promulgate the regulation Sacred Heart requests, and its failure to do so is not arbitrary and capricious.

neglected to refer to (b)(4)(A) explicitly. In *The Methodist Hospital v. Sullivan*, No. 90-1871, 1991 WL 263110, at *3 (D.D.C. Sept. 20, 1991), the district court similarly declined to adopt the Secretary's interpretation of the PPS noting: [T]he structure, specific wording, and legislative history of the statute suggest that Congress did mean to include (b)(4)(A) in the phase-in period calculations. The whole point of the phase-in provisions is to implement PPS gradually, by blending the old and new payment systems; and the old system included (b)(4)(A)

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[B]y all outward appearances, the transition period was designed to soften the blow dealt by the new system to hospitals, but, according to the Secretary's interpretation, this period would effectively become a Trojan horse inside which a further cost-cutting measure was hidden.[34]

With all due respect, we regard these interpretations as flawed. First, the PPS does not refer to §1395ww(b)(4)(A), although it does refer to §1395ww(b)(3)(A). This omission is significant, because if Congress had intended to retain the "extraordinary

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[34] Although other courts have awarded relief similar to that which Sacred Heart seeks here, they did not specifically address the argument advanced here because the Secretary did not dispute the reimbursement. See, e.g., *Greenville Hospital System v. Heckler*, 642 F.Supp. 15, 17 (D.S.C. 1985), vacated, Medicare & Medicaid Guide (CCH) P 36,072, 1986 WL 68493 (D.S.C. 1986); *Redbud Hospital District v. Heckler*, No. C-84-4382- MHP, slip op. at 18, 1984 WL 2857 (N.D. Cal. June 14, 1985) (the Secretary "does not dispute that this provision is directed to the calculation of the target amount under the reimbursement system in effect for 1983-84, which directly translates into the PPS hospital-specific rate."), vacated on other grounds, 473 U.S. 1308, 106 S.Ct. 1, 87 L.Ed.2d 677 (1986).

circumstances" provision, it would have so indicated. Second, §1395ww(b)(3)(A) does not refer to §1395ww(b)(4)(A), although it does refer to subparagraphs (C), (D) and (E), which constitute exceptions from the target amount method set forth in (b)(3)(A). Thus, by §1395ww(b)(3)(A)'s own terms, there is no need to incorporate §1395ww(b)(4)(A) to ensure a proper calculation of a hospital's target amount. Third, the PPS contains a provision endowing the Secretary with authority to promulgate regulations concerning exceptions to the reimbursement system. Therefore, there is no need to incorporate a provision in §1395ww(b)(4)(A) which endows the Secretary with arguably lesser authority to deviate from the target amount method set forth in §1395ww(b)(3)(A). Fourth, these interpretations are inconsistent with Congress' intent to move away from the retrospective reimbursement system and create a forward-looking system with fixed rates.[35]

IV. CONCLUSION

In conclusion, the HCFA's position that the PPS does not incorporate TEFRA's "extraordinary circumstances"

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35 This interpretation of the PPS is consistent with the decision of the United States Court of Appeals for the District of Columbia Circuit in *Georgetown University Hospital v. Bowen*, 862 F.2d 323. There, the Court stated that, by enacting the four-year transition period, Congress "clearly signalled an intent to keep certain elements of the former system in place at least temporarily." Id. at 327 (emphasis supplied). Further, in determining the definition of "allowable operating costs" under TEFRA, the Court referred to the statutory language, which provided that such costs were those incurred in the "preceding 12-month cost reporting period." Id. at 326. In light of these determinations, there is no need to reach Sacred Heart's contention that the increase in inpatient operating costs due to the new facility constitutes an emergency circumstance within the meaning of §1395ww(b)(4)(A).

exception is not unreasonable. Neither the PPS, nor §1395ww(b)(3)(A) expressly refers to §1395ww(b)(4)(A). Further, the PPS contains its own provision endowing the Secretary with authority to create exceptions to the amount of reimbursement that would otherwise be afforded under the PPS; the HCFA, exercising the power delegated to it by the Secretary, has not promulgated a regulation permitting modifications for emergency circumstances.

In addition, the legislative history confirms Congress' intent to break from the retrospective system of reimbursement; accordingly, exceptions for increases in a provider's HSP due to increases in its actual operating costs should not be permitted absent clear congressional intent to do so. Finally, although the HCFA espoused a different interpretation of the PPS previously, it has offered a reasonable justification for its new position.

For these reasons, the judgment of the district court will be reversed and the matter will be remanded to the district court for entry of a summary judgment in favor of the Secretary.[36]

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36 Judge Seitz agrees that the present state of the law dictates the result here reached. However, he believes that, if administratively permissible under the Act, a kinder, gentler and more equitable administration of the Act would justify the granting of administrative relief in the present situation. He so believes because (1) the Secretary did not oppose reimbursement in some earlier cases on the ground now asserted, thus resulting in invidious treatment here, (2) the factors that caused the delay that prejudiced the Medical Center were not its fault and (3) to grant relief in this relatively sui generis situation would not impede the prospective system incorporated in PPS.

APPENDIX M --- UNITED STATES CODE, TITLE 42, THE PUBLIC HEALTH AND WELFARE, §1395ww(a)

(a) Determination of costs for inpatient hospital services; limitations; exemptions; "operating costs of inpatient hospital services" defined

(1)(A)(i) The Secretary, in determining the amount of the payments that may be made under this subchapter with respect to operating costs of inpatient hospital services (as defined in paragraph (4)) shall not recognize as reasonable (in the efficient delivery of health services) costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage (as determined under clause (ii)) of the average of such costs for all hospitals in the same grouping as such hospital for comparable time periods.

(ii) For purposes of clause (i), the applicable percentage for hospital cost reporting periods beginning--

(I) on or after October 1, 1982, and before October 1, 1983, is 120 percent;

(II) on or after October 1, 1983, and before October 1, 1984, is 115 percent; and

(III) on or after October 1, 1984, is 110 percent.

(B)(i) For purposes of subparagraph (A) the Secretary shall establish case mix indexes for all short-term hospitals, and shall set limits for each hospital based upon the general mix of types of medical cases with respect to which such hospital

provides services for which payment may be made under this subchapter.

(ii) The Secretary shall set such limits for a cost reporting period of a hospital--

(I) by updating available data for a previous period to the immediate preceding cost reporting period by the estimated average rate of change of hospital costs industry-wide, and

(II) by projecting for the cost reporting period by the applicable percentage increase (as defined in subsection (b)(3)(B) of this section).

(C) The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this subchapter for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

(D) Subparagraph (A) shall not apply to cost reporting periods beginning on or after October 1, 1983.

(2) The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account--

(A) the special needs of sole community hospitals, of new hospitals, of risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital's control, medical and paramedical education costs, significantly fluctuating

population in the service area of the hospital, and unusual labor costs,

(B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter, and

(C) a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

(3) The limitation established under paragraph (1)(A) shall not apply with respect to any hospital which--

(A) is located outside of a standard metropolitan statistical area, and

(B)(i) has less than 50 beds, and

(ii) was in operation and had less than 50 beds on September 3, 1982.

(4) For purposes of this section, the term "operating costs of inpatient hospital services" includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis (as determined by the Secretary), and includes the costs of all services for which payment may be made under this subchapter that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of the patient's admission if

such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary). Such term does not include costs of approved educational activities, a return on equity capital, or, other capital-related costs (as defined by the Secretary for periods before October 1, 1987).

APPENDIX N --- UNITED STATES CODE, TITLE 42, THE PUBLIC HEALTH AND WELFARE, §1395ww(b)

(b) Computation of payment; definitions; exemptions; adjustments

(1) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, if the operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B) of this section) for a cost reporting period subject to this paragraph--

(A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A of this subchapter on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus--

(i) 50 percent of the amount by which the target amount exceeds the amount of the operating costs, or

(ii) 5 percent of the target amount,

whichever is less; or

(B) are greater than the target amount, the amount of the payment with respect to such operating costs payable under part A of this subchapter on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1991, an additional amount

equal to 50 percent of the amount by which the operating costs exceed the target amount (except that such additional amount may not exceed 10 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period;

except that in no case may the amount payable under this subchapter (other than on the basis of a DRG prospective payment rate determined under subsection (d) of this section) with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a) of this section.

(2) Repealed. Pub.L. 98-21, Title VI, §601(b)(4), Apr. 20, 1983, 97 Stat. 150

(3)(A) Except as provided in subparagraphs (C), (D), and (E), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period--

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

(B)(i) For purposes of subsection (d) of this section for discharges occurring during a fiscal year, the "applicable percentage increase" shall be--

(I) for fiscal year 1986, 1/2 percent,

(II) for fiscal year 1987, 1.15 percent,

(III) for fiscal year 1988, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D) of this section), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year 1989, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year 1990, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year 1991, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year 1992, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage

increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year 1993, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 for hospitals located in a rural area,

(IX) for fiscal year 1994, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year 1995, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) of this section for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

(XI) for fiscal year 1996, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

(XII) for fiscal year 1997, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas, and

(XIII) for fiscal year 1998 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.

(ii) For purposes of subparagraphs (A) and (E), the "applicable percentage increase" for 12-month cost reporting periods beginning during--

(I) fiscal year 1986, is 0.5 percent,

(II) fiscal year 1987, is 1.15 percent,

(III) fiscal year 1988, is the market basket percentage increase minus 2.0 percentage points,

(IV) a subsequent fiscal year ending on or before September 30, 1993, is the market basket percentage increase,

(V) fiscal years 1994 through 1997, is the market basket percentage increase minus the applicable reduction (as defined in clause (v)(II)), or in the case of a hospital for a fiscal year for which the hospital's update adjustment percentage (as defined in clause (v)(I)) is at least 10 percent, the market basket percentage increase, and

(VI) subsequent fiscal years is the market basket percentage increase.

(iii) For purposes of this subparagraph, the term "market basket percentage increase" means, with respect to cost reporting periods and discharges occurring in a fiscal year, the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of

such mix of goods and services for the preceding 12- month cost reporting period or fiscal year.

(iv) For purposes of subparagraphs (C) and (D), the "applicable percentage increase" is--

(I) for 12-month cost reporting periods beginning during fiscal years 1986 through 1993, the applicable percentage increase specified in clause (ii),

(II) for fiscal year 1994, the market basket percentage increase minus 2.3 percentage points (adjusted to exclude any portion of a cost reporting period beginning during fiscal year 1993 for which the applicable percentage increase is determined under subparagraph (I)),

(III) for fiscal year 1995, the market basket percentage increase minus 2.2 percentage points, and

(IV) for fiscal year 1996 and each subsequent fiscal year, the applicable percentage increase under clause (i).

(v) For purposes of clause (ii)(V)--

(I) a hospital's "update adjustment percentage" for a fiscal year is the percentage by which the hospital's allowable operating costs of inpatient hospital services recognized under this subchapter for the cost reporting period beginning in fiscal year 1990 exceeds the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, increased for each fiscal year (beginning with fiscal year 1994) by the sum of any of the hospital's applicable reductions under subclause (V) for previous fiscal years; and

(II) the "applicable reduction" with respect to a hospital for a fiscal year is the lesser of 1 percentage point or the

percentage point difference between 10 percent and the hospital's update adjustment percentage for the fiscal year.

(C) In the case of a hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii) of this section) the term "target amount" means--

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital--

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by--

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period,

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for discharges occurring in the fiscal year in which that later cost reporting period begins,

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the applicable percentage increase under subparagraph (B)(iv), or

(iv) with respect to discharges occurring in fiscal year 1995 and each subsequent fiscal year, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(D) For cost reporting periods ending on or before September 30, 1994, in the case of a hospital that is a Medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G) of this section), the term "target amount" means--

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital--

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by--

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for

discharges occurring in the fiscal year in which that later cost reporting period begins, and

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(E) In the case of a hospital described in clause (v) of subsection (d)(1)(B) of this section, the term "target amount" means--

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital--

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by--

(II) the sum of the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(4)(A)(i) The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services. The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.

(ii) The payment reductions under paragraph (3)(B)(ii)(V) shall not be considered by the Secretary in making adjustments pursuant to clause (i).

(B) In determining under subparagraph (A) whether to assign a new base period which is more representative of the reasonable and necessary cost to a hospital of providing inpatient services, the Secretary shall take into consideration--

(i) changes in applicable technologies and medical practices, or differences in the severity of illness among patients, that increase the hospital's costs;

(ii) whether increases in wages and wage-related costs for hospitals located in the geographic area in which the hospital is located exceed the average of the increases in such costs paid by hospitals in the United States; and

(iii) such other factors as the Secretary considers appropriate in determining increases in the hospital's costs of providing inpatient services.

(C) Paragraph (1) shall not apply to payment of hospitals which is otherwise determined under paragraph (3) of section 1395f(b) of this title.

(5) In the case of any hospital having any cost reporting period of other than a 12-month period, the Secretary shall determine the 12-month period which shall be used for purposes of this section.

(6) In the case of any hospital which becomes subject to the taxes under section 3111 of Title 26, with respect to any or all of its employees, for part or all of a cost reporting period, and was not subject to such taxes with respect to any or all of

its employees for all or part of the 12-month base cost reporting period referred to in subsection (b)(3)(A)(i) of this section, the Secretary shall provide for an adjustment by increasing the base period amount described in such subsection for such hospital by an amount equal to the amount of such taxes which would have been paid or accrued by such hospital for such base period if such hospital had been subject to such taxes for all of such base period with respect to all its employees, minus the amount of any such taxes actually paid or accrued for such base period.

APPENDIX O --- UNITED STATES CODE, TITLE 42, THE PUBLIC HEALTH AND WELFARE, §1395ww(d)

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographic Classification Review Board

(1)(A) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year---

(i) beginning on or after October 1,1983, and before October 1, 1984, is equal to the sum of---

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A) of this section, but determined without the application of subsection (a) of this section), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, 1987, is equal to the sum of---

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A) of this section, but determined without the application of subsection (a) of this section), and

(II) the DRG percentage (as defined in subparagraph (C)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after April 1, 1988, is equal to--

(I) the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, or

(II) for discharges occurring during a fiscal year ending on or before September 30, 1996, the sum of 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges and 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph, but only if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same large urban or other area (or, for discharges occurring during a fiscal year ending on or before September 30, 1994, the same large urban or other urban area) as, the hospital is greater than the average standardized amount (described in the respective clause) for

hospitals within the United States in that type of area for discharges occurring during such fiscal year.

APPENDIX P --- CODE OF FEDERAL REGULATIONS, TITLE 42, PUBLIC HEALTH, §412.71

§412.71 Determination of base-year inpatient operating costs.

(a) Base-year costs.

(1) For each hospital, the intermediary will estimate the hospital's Medicare Part A allowable inpatient operating costs, as described in §412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1982 and before September 30, 1983.

(2) If the hospital's last cost reporting period ending before September 30, 1983 is for less than 12 months, the base period will be the hospital's most recent 12-month or longer cost reporting period ending before such short reporting period, with an appropriate adjustment for inflation. (The rules applicable to new hospitals are set forth in §412.74.)

(b) Modifications to base-year costs. Prior to determining the hospital- specific rate, the intermediary will adjust the hospital's estimated base-year inpatient operating costs, as necessary, to include malpractice insurance costs in accordance with §413.53(a)(1)(i) of this chapter, and exclude the following:

(1) Medical education costs as described in §413.85 of this chapter.

(2) Capital-related costs as described in ¨413.130 of this chapter.

(3) Kidney acquisition costs incurred by hospitals approved as renal transplantation centers as described in §412.100. Kidney acquisition costs in the base year will be determined by multiplying the hospital's average kidney acquisition cost per kidney times the number of kidney transplants covered by Medicare Part A during the base period.

(4) Higher costs that were incurred for purposes of increasing base-year costs.

(5) One-time nonrecurring higher costs or revenue offsets that have the effect of distorting base-year costs as an appropriate basis for computing the hospital-specific rate.

(6) Higher costs that result from changes in hospital accounting principles initiated in the base year.

(7) The costs of qualified nonphysician anesthetists' services, as described in §412.113(c).

(c) Hospital's request for adjustment of base-year inpatient operating costs.

(1) Before the date it becomes subject to the prospective payment system for inpatient operating costs, a hospital may request the intermediary to further adjust its estimated base-period costs to take into account the following:

(i) Services paid for under Medicare Part B during the hospital's base year that will be paid for under prospective payments. The base-year costs may be increased to include estimated payments for certain services previously billed as physicians' services before the effective date of §405.550(b) of this chapter, and estimated payments for nonphysicians' services that were not furnished either directly or under arrangements before October 1, 1983 (the effective date of

§405.310(m) of this chapter), but may not include the costs of anesthetists' services for which a physician employer continues to bill under §405.553(b)(4) of this chapter.

(ii) The payment of FICA taxes during cost reporting periods subject to the prospective payment system, if the hospital had not paid such taxes for all its employees during its base period and will be required to participate effective January 1, 1984.

(2) If a hospital requests that its base-period costs be adjusted under paragraph (c)(1) of this section, it must timely provide the intermediary with sufficient documentation to justify the adjustment, and adequate data to compute the adjusted costs. The intermediary decides whether to use part or all of the data on the basis of audit, survey and other information available.

(d) Intermediary's determination. The intermediary uses the best data available at the time in estimating each hospital's base-year costs and the modifications to those costs authorized by paragraphs (b) and (c) of this section. The intermediary's estimate of base-year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided in §412.72.

APPENDIX Q --- CODE OF FEDERAL REGULATIONS, TITLE 42, PUBLIC HEALTH, §412.72

§412.72 Modification of base-year costs.

(a) Bases for modification of base-year costs. Base-year costs as determined under §412.71(d) may be modified under the following circumstances:

(1) Inadvertent omissions.

(i) A hospital that becomes subject to the prospective payment system beginning on or after October 1, 1983 and before November 16, 1983 has until November 15, 1983 to request its intermediary to re-estimate its base-period costs to take into account inadvertent omissions in its previous submissions to the intermediary related to changes made by the prospective payment legislation for purposes of estimating the base-period costs.

(ii) The intermediary may also initiate changes to the estimation--

(A) For any reason before the date the hospital becomes subject to prospective payment; and

(B) Before November 16, 1983, for corrections to take into account inadvertent omissions in the hospital's previous submissions related to changes made by the prospective payment legislation for purposes of estimating the base-period costs.

(iii) Such omissions pertain to adjustments to exclude capital-related costs and the direct medical education costs of

approved educational activities and to adjustments specified in §412.71(c).

(iv) The intermediary must notify the provider of any change to the hospital- specific amount as a result of the provider's request within 30 days of receipt of the additional data.

(v) Any change to base-period costs made under this paragraph (a)(1) will be made effective retroactively, beginning with the first day of the affected hospital's fiscal year.

(2) Correction of mathematical errors of calculations.

(i) The hospital must report mathematical errors of calculations to the intermediary within 90 days of the intermediary's notification to the hospital of the hospital's payments rates.

(ii) The intermediary may also identify such errors and initiate their correction during this period.

(iii) The intermediary will either make an appropriate adjustment or notify the hospital that no adjustment is warranted within 30 days of receipt of the hospital's report of an error.

(iv) Corrections of errors of calculation will be effective with the first day of the hospital's first cost reporting period subject to the prospective payment system.

(3) Recognition of additional costs.

(i) The intermediary may adjust base period costs to take into account additional costs recognized as allowable costs for the hospital's base year as the result of any of the following:

(A) A reopening and revision of the hospital's base-year notice of amount of program reimbursement under §§405.1885 through 405.1889 of this chapter.

(B) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under §405.1821 or §405.1853 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(C) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of HCFA under §405.1875 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(D) An administrative or judicial review decision under §§405.1831, 405.1871, or 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(ii) The intermediary will recalculate the hospital's base-year costs, incorporating the additional costs recognized as allowable for the hospital's base year. Adjustments to base-year costs to take into account these additional costs--

(A) Will be effective with the first day of the hospital's first cost reporting period beginning on or after the date of the revision, order or finding, or review decision; and

(B) Will not be used to recalculate the hospital-specific portion as determined for fiscal years beginning before the date of the revision, order or finding, or review decision.

(4) Successful appeal. The intermediary may modify base-year costs to take into account a successful appeal relating to modifications to base-year costs that were made under §412.71(b). If a hospital successfully contests a modification to base-year costs--

(i) The intermediary will recalculate the hospital's base-year costs to reflect the modification determined appropriate as a result of the appeal; and

(ii) Such adjustments will be effective retroactively to the time of the intermediary's initial estimation of base-year costs.

(5) Unlawfully claimed costs. The intermediary may modify base-year costs to exclude costs that were unlawfully claimed as determined as a result of criminal conviction, imposition of a civil judgment under the False Claims Act (31 U.S.C. 3729-3731), or a proceeding for exclusion from the Medicare program. In addition to adjusting base-year costs, HCFA will recover both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates. The amount to be recovered will be computed on the basis of the final resolution of the amount of the inappropriate base-year costs.

(b) Right to administrative and judicial review.

(1) An intermediary's estimation of a hospital's base-year costs, and modifications, made for purposes of determining the hospital-specific rate, are subject to administrative and judicial review. Review will be available to a hospital upon receipt of its notice of amount of program reimbursement following the close of its cost reporting period, but only with

respect to whether the intermediary followed the provisions of §§412.71 and 412.72. (Sections 405.1803 and 405.1807 of this chapter set forth the rules for intermediary determinations and notice of amount of program reimbursement and the effect of those determinations.)

(2) In any administrative or judicial review of whether the intermediary used the best data available at the time, as required by §412.71(d), an intermediary's estimation will be revised on the basis of this review only if the estimation was unreasonable and clearly erroneous in light of the data available at the time the estimation was made.

(3) Specifically excluded from administrative or judicial review are any issues based on data, information, or arguments not presented to the intermediary at the time of the estimation.

APPENDIX R --- SENATE REPORT NO. 23, 98th CONGRESS, 1st SESSION 1983

3. EFFECTIVE DATE/TRANSITION

PRESENT LAW

UNDER CURRENT LAW, THE SECTION 223 LIMITS ARE AUTHORIZED INDEFINITELY; THE RATE OF INCREASE LIMITS DO NOT APPLY TO HOSPITAL COSTS REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1985.

COMMITTEE AMENDMENT

THE PROSPECTIVE PAYMENT SYSTEM WOULD BE EFFECTIVE FOR INDIVIDUAL HOSPITAL ACCOUNTING YEARS BEGINNING ON OR AFTER OCTOBER 1, 1983, AND WOULD BE PHASED-IN OVER A THREE YEAR PERIOD. IN YEAR ONE, 25 PERCENT OF THE PAYMENT WOULD BE BASED ON A COMBINATION OF NATIONAL AND REGIONAL DRG RATES (25 PERCENT NATIONAL, 75 PERCENT REGIONAL AND REGIONAL DRG RATES (25 PERCENT NATIONAL, 75 PERCENT REGIONAL); 75 PERCENT WOULD BE BASED ON EACH HOSPITAL'S OWN COST-BASED EXPERIENCE. IN YEAR TWO, 50 PERCENT OF THE PAYMENT WOULD BE BASED ON A COMBINATION OF NATIONAL AND REGIONAL DRG RATES (50 PERCENT EACH); 50 PERCENT WOULD BE BASED ON EACH HOSPITAL'S COST EXPERIENCE. IN YEAR THREE, 75 PERCENT OF THE PAYMENT WOULD BE BASED ON A COMBINATION OF DRG RATES (75 PERCENT NATIONAL, 25 PERCENT REGIONAL); 25 PERCENT WOULD BE

BASED ON EACH HOSPITAL'S COST EXPERIENCE. IN YEAR FOUR, THE ENTIRE PAYMENT WOULD BE BASED ON NATIONAL DRG RATES, CALCULATED SEPARATELY FOR HOSPITALS LOCATED IN URBAN AND RURAL AREAS. THE PHASE-IN OF NATIONAL DRG RATES OVER THE THREE-YEAR PERIOD IS DESIGNED TO MINIMIZE DISRUPTION THAT MIGHT OTHERWISE OCCUR BECAUSE OF SUDDEN CHANGES IN REIMBURSEMENT LEVELS. THE SECTION 223 LIMITS PROVIDED UNDER CURRENT LAW WOULD BE REPEALED EFFECTIVE FOR HOSPITAL COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1983. HOWEVER, HOSPITALS OR UNITS OF HOSPITALS NOT INCLUDED IN THE PROSPECTIVE PAYMENT SYSTEM WOULD BE SUBJECT TO THE SAME RATE OF INCREASE LIMITATION AS CONTAINED IN TEFRA, INCLUDING THE PENALTIES AND BONUSES. THE RATE OF INCREASE USED TO UPDATE THESE LIMITS WOULD BE THAT WHICH IS CURRENTLY CONTAINED IN TEFRA, MARKET BASKET PLUS ONE PERCENTAGE POINT.

4. EXEMPTIONS, EXCEPTIONS AND ADJUSTMENTS

PRESENT LAW

UNDER CURRENT LAW, SECTION 223 LIMITS DO NOT APPLY TO CHILDREN'S HOSPITALS, PSYCHIATRIC HOSPITALS, LONG-TERM CARE HOSPITALS OR TO RURAL HOSPITALS WITH LESS THAN 50 BEDS. IN ADDITION, THE SECRETARY IS REQUIRED TO PROVIDE EXEMPTIONS, EXCEPTIONS AND ADJUSTMENTS TO THE LIMITS AS HE DEEMS APPROPRIATE TO TAKE INTO ACCOUNT THE SPECIAL NEEDS OF PSYCHIATRIC, PUBLIC AND

OTHER HOSPITALS THAT SERVE A DISPROPORTIONATE NUMBER OF LOW-INCOME AND MEDICARE BENEFICIARIES AND SOLE COMMUNITY PROVIDERS. CURRENT LAW ALSO REQUIRES THE SECRETARY TO PROVIDE EXEMPTIONS, EXCEPTIONS AND ADJUSTMENTS TO THE SECTION 223 LIMITS AS HE DEEMS APPROPRIATE TO TAKE INTO ACCOUNT THE SPECIAL NEEDS OF NEW HOSPITALS, RISK-BASED HEALTH MAINTENANCE ORGANIZATIONS, AND HOSPITALS PROVIDING ATYPICAL OR ESSENTIAL SERVICES; EXTRAORDINARY CIRCUMSTANCES BEYOND A HOSPITAL'S CONTROL; AND FOR OTHER PURPOSES.

COMMITTEE AMENDMENT

UNDER THE COMMITTEE AMENDMENT, PSYCHIATRIC, LONG-TERM CARE, REHABILITATION AND CHILDREN'S HOSPITALS WOULD BE SPECIFICALLY EXEMPTED FROM THE PROSPECTIVE PAYMENT SYSTEM. THE DRG CLASSIFICATION SYSTEM WAS DEVELOPED FOR SHORT-TERM ACUTE CARE GENERAL HOSPITALS AND, AS CURRENTLY CONSTRUCTED, DOES NOT ADEQUATELY TAKE INTO ACCOUNT SPECIAL CIRCUMSTANCES OF DIAGNOSES REQUIRING LONG STAYS AND AS USED IN THE MEDICARE PROGRAM IS INAPPROPRIATE FOR CERTAIN CLASSES OF PATIENTS. IN ADDITION, DISTINCT PART REHABILITATION OR PSYCHIATRIC UNITS OF ACUTE CARE HOSPITALS WOULD BE EXEMPT. THE SECRETARY, UNDER CURRENT MEDICARE RULES AND REGULATIONS, HAS PRESCRIBED IN DETAIL STANDARDS AND CRITERIA THAT DISTINCT PARTS MUST MEET INCLUDING ESTABLISHMENT OF

SEPARATE COST ENTITIES FOR COST REIMBURSEMENT AND REQUIREMENTS THAT SUCH UNITS HAVE A SUB-PROVIDER IDENTIFICATION NUMBER. THE SECRETARY WOULD BE REQUIRED TO PROVIDE FOR EXCEPTIONS AND ADJUSTMENTS TO TAKE INTO ACCOUNT THE SPECIAL CIRCUMSTANCES FACED BY SOLE COMMUNITY PROVIDERS. SUCH PROVIDERS WILL BE PAID ON THE SAME BASIS AS ALL OTHER PROVIDERS ARE PAID IN YEAR ONE: 25 PERCENT OF THE PAYMENT WOULD BE BASED ON A BLEND OF RURAL NATIONAL AND REGIONAL DRG RATES (25 PERCENT NATIONAL, 75 PERCENT REGIONAL); 75 PERCENT WOULD BE BASED ON EACH HOSPITAL'S OWN COST EXPERIENCE. IN NO CASE WOULD TOTAL PAYMENTS IN ANY ONE TRANSITION YEAR BE LESS THAN THE PAYMENTS MADE IN THE PRECEDING YEAR. THE COMMITTEE IS CONCERNED THAT, IN DETERMINING WHICH HOSPITALS HAVE BEEN ELIGIBLE FOR EXCEPTIONS AND ADJUSTMENTS AS SOLE COMMUNITY PROVIDERS IN THE PAST, THE SECRETARY HAS APPLIED DIFFERENT CRITERIA IN THE DIFFERENT REGIONS OF THE COUNTRY, INCLUDING SOME WHICH ARE VERY NARROW AND RESTRICTIVE. THEREFORE, THE COMMITTEE EXPECTS THAT THE SECRETARY, IN MAKING SUCH DETERMINATIONS FOR SOLE COMMUNITY PROVIDERS UNDER THE NEW PROSPECTIVE PAYMENT SYSTEM, WILL DEVELOP AND TAKE INTO ACCOUNT A MUCH BROADER RANGE OF FACTORS RELATING TO BENEFICIARY ACCESS TO BASIC HOSPITAL SERVICES. THE COMMITTEE AMENDMENT FURTHER DIRECTS THE SECRETARY TO STUDY THE PROBLEMS OF PAYING SOLE COMMUNITY PROVIDERS AND REPORT BACK TO THE CONGRESS,

BY APRIL 1, 1985, ON EQUITABLE METHODS OF PAYING THESE SMALL RURAL HOSPITALS WHICH TAKE ACCOUNT OF THEIR UNIQUE CIRCUMSTANCES, INCLUDING THEIR VULNERABILITY TO SUBSTANTIAL VARIATIONS IN OCCUPANCY RATES. UNDER THIS AMENDMENT, THE SECRETARY WOULD ALSO BE REQUIRED TO PROVIDE EXCEPTIONS AND ADJUSTMENTS, AS HE DEEMS APPROPRIATE, TO TAKE INTO ACCOUNT THE SPECIAL NEEDS OF PUBLIC OR OTHER HOSPITALS THAT SERVE A DISPROPORTIONATELY LARGE NUMBER OF LOW-INCOME AND PART A MEDICARE BENEFICIARIES. CONCERN HAS BEEN EXPRESSED THAT PUBLIC HOSPITALS AND OTHER HOSPITALS THAT SERVE SUCH PATIENTS MAY BE MORE SEVERELY ILL THAN AVERAGE AND THAT THE DRG PAYMENT SYSTEM MAY NOT ADEQUATELY TAKE INTO ACCOUNT SUCH FACTORS. THE SECRETARY IN HIS REPORT TO CONGRESS STATED THAT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES WOULD CONTINUE TO STUDY WAYS OF TAKING ACCOUNT OF SEVERITY OF ILLNESS IN THE DRG SYSTEM. EXCEPTIONS AND ADJUSTMENTS WOULD ALSO BE PERMITTED TO TAKE INTO ACCOUNT THE SPECIAL NEEDS OF HOSPITALS LOCATED IN ALASKA AND HAWAII, AS THE SECRETARY NOW DOES IN APPLYING THE REIMBURSEMENT LIMITS OF PRESENT LAW. THIS PROVISION WOULD EXEMPT FROM THE PROSPECTIVE PAYMENT SYSTEM HOSPITALS LOCATED IN GEOGRAPHIC AREAS OUTSIDE THE FIFTY STATES AND THE DISTRICT OF COLUMBIA BUT WITHIN THE UNITED STATES FOR PURPOSES OF MEDICARE (I.E. TERRITORIES). THE COST EXPERIENCE OF THESE HOSPITALS MAY BE SO VARIED THAT THE DRG PROSPECTIVE

PAYMENT SYSTEM MAY NOT ADEQUATELY REFLECT THE NEEDS OF THESE HOSPITALS.

Supreme Court, U.S.
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No. 95-98

In the Supreme Court of the United States

OCTOBER TERM, 1995

HILLSBOROUGH COUNTY HOSPITAL AUTHORITY, ET AL.,
PETITIONERS

v.

DONNA E. SHALALA,
SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Whether a now-superseded Medicare reimbursement provision, 42 U.S.C. 1395ww(b)(4)(A) (1982), was implicitly incorporated into another now-superseded reimbursement provision, 42 U.S.C. 1395ww(d)(1)(A)(i)-(ii) (Supp. V 1987), from 1983 to 1987.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statement	2
Argument	8
Conclusion	10

TABLE OF AUTHORITIES

Cases:

Community Hospital of Chandler v. *Sullivan*, 963 F.2d 1206 (9th Cir. 1992)	8
Episcopal Hospital v. *Shalala:*	
994 F.2d 879 (D.C. Cir. 1993), cert. denied, 114 S. Ct. 876 (1994)	7, 10
114 S. Ct. 876 (1994)	2, 8
Methodist Hospital v. *Shalala*, 114 S. Ct. 2162 (1994)	2, 8
Sacred Heart Medical Center v. *Sullivan*, 958 F.2d 537 (3d Cir. 1992)	7

Statutes and regulations:

Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324	2
§ 101(a)(1), 96 Stat. 332-334	3
42 U.S.C. 1395c (Supp. V 1993)	2
42 U.S.C. 1395f(b)	2
42 U.S.C. 1395x(v)(1)(A)	2
42 U.S.C. 1395ww(b)(1)(A) (1982)	3
42 U.S.C. 1395ww(b)(1)(B) (1982)	3
42 U.S.C. 1395ww(b)(3)(A) (1982)	3, 6, 7
42 U.S.C. 1395ww(b)(3)(A)(i) (1982)	3
42 U.S.C. 1395ww(b)(3)(A)(ii) (1982)	3
42 U.S.C. 1395ww(b)(4)(A) (1982)	2, 3, 4, 7, 8, 9, 10
42 U.S.C. 1395ww(d) (1988 & Supp. V 1993)	4
42 U.S.C. 1395ww(d)(1) (1988 & Supp. V 1993)	4
42 U.S.C. 1395ww(d)(1)(A)(i)-(ii) (Supp. V 1987)	2

Statutes and regulations—Continued: Page

42 U.S.C. 1395ww(d)(1)(A)(i)(I) (Supp. V 1987) 5, 6
42 U.S.C. 1395ww(d)(1)(A)(i)(II) (Supp. V 1987) 5
42 U.S.C. 1395ww(d)(1)(A)(ii)(I) (Supp. V 1987) 5, 6
42 U.S.C. 1395ww(d)(1)(A)(ii)(II) (Supp. V 1987) 5
42 U.S.C. 1395ww(d)(1)(B) (1988 & Supp. V 1993) 4
42 U.S.C. 1395ww(d)(1)(C) (Supp. V 1987) 5
42 U.S.C. 1395ww(d)(2)-(3) (1988 & Supp. V 1993) 4
42 U.S.C. 1395ww(d)(4) (1988 & Supp. V 1993) 4
42 U.S.C. 1395ww(d)(5) (1988 & Supp. V 1993) 6
42 U.S.C. 1395ww(d)(5)(A)-(H) (1988 & Supp. V 1993) 6
42 U.S.C. 1395ww(d)(5)(I) (Supp. V 1993) 6
42 U.S.C. 1395ww(g) (1988 & Supp. V 1993) 4
42 C.F.R.:
Section 412.60 4
Section 412.62 4
Section 412.63 4
Sections 412.70-412.76 6
Section 412.71(b)-(c) 6
Section 412.72(a) 6
Sections 412.300 *et seq.* 4
Section 413.40 3
Section 413.40(e)-(i) 3
Section 413.40(g)(2) 4

Miscellaneous:

H.R. Rep. No. 25, 98th Cong., 1st Sess. Pt. 1 (1983) .. 5

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BRIEF FOR THE RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-4a) is reported at 49 F.3d 1416. The order of the district court (Pet. App. 7a-8a) and the report and recommendation of the magistrate judge (Pet. App. 11a-17a) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on April 19, 1995. The petition for a writ of certiorari was filed on July 18, 1995. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

The issue in this case is whether 42 U.S.C. 1395ww(b)(4)(A) (1982), a now-superseded Medicare reimbursement provision, was incorporated into 42 U.S.C. 1395ww(d)(1)(A)(i)-(ii) (Supp. V 1987), another now-superseded reimbursement provision, from 1983 to 1987. This Court has recently denied certiorari in two other cases presenting the same issue, *Episcopal Hospital* v. *Shalala*, 114 S. Ct. 876 (1994), and *Methodist Hospital* v. *Shalala*, 114 S. Ct. 2162 (1994).

1. Petitioners are hospitals that are seeking retroactive increases in Medicare reimbursements for certain inpatient hospital care provided during the mid-1980s. Part A of the Medicare program provides elderly and disabled persons with "basic protection against the costs of hospital, related post-hospital, home health services, and hospice care." 42 U.S.C. 1395c (Supp. V 1993). Prior to 1983, hospital reimbursement under Part A was based primarily on the "reasonable cost" of covered services. 42 U.S.C. 1395f(b). The Medicare program defines "reasonable cost" to mean "the cost actually incurred," exclusive of costs "found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. 1395x (v)(1)(A). When a hospital's costs of providing covered services increased, so did its Part A reimbursement.

In 1982, in an effort to curb cost increases and encourage greater efficiency, Congress imposed greater limits on Part A reimbursement as part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, 96 Stat. 324. TEFRA left the basic retrospective, cost-based methodology of Part A reimbursement undisturbed, but added financial incentives and penalties to slow the rate of

increase in reimbursements for inpatient hospital services. See TEFRA § 101(a)(1), 96 Stat. 332-334.

TEFRA's rate-of-increase scheme was tied to a "target amount" for each hospital, which was defined in 42 U.S.C. 1395ww(b)(3)(A) (1982). For the hospital's initial cost reporting period, Subsection (b)(3)(A) defined "target amount" as "the allowable operating costs of inpatient hospital services * * * recognized * * * for such hospital for the preceding 12-month cost reporting period." 42 U.S.C. 1395ww(b)(3)(A)(i) (1982). For each subsequent reporting period, the target amount was increased annually by a specified percentage. 42 U.S.C. 1395ww(b)(3)(A)(ii) (1982). If a hospital's operating costs were less than the applicable target amount during a reporting period, the hospital received a bonus. 42 U.S.C. 1395ww(b)(1)(A) (1982). Conversely, if the hospital's operating costs exceeded the target amount, its reimbursement was reduced. 42 U.S.C. 1395ww(b)(1)(B) (1982); see generally 42 C.F.R. 413.40.

At the same time that TEFRA created a rate-of-increase limit on Part A reimbursements, it also provided for exceptions and adjustments under 42 U.S.C. 1395ww(b)(4)(A) (1982). Subsection (b)(4)(A) generally authorized the Secretary of Health and Human Services to "provide for such * * * exemptions from, and exceptions and adjustments to, [the rate-of-increase reimbursement] method as the Secretary deems appropriate." 42 U.S.C. 1395ww(b)(4)(A) (1982); see generally 42 C.F.R. 413.40(e)-(i). Subsection (b)(4)(A) also specifically directed the Secretary to "provide for an exemption from, or an exception and adjustment to, the [rate-of-increase] method * * * where events beyond the hospital's control or extraordinary circumstances * * * create a

distortion in the increase in costs for a cost reporting period." 42 U.S.C. 1395ww(b)(4)(A) (1982); see 42 C.F.R. 413.40(g)(2).

2. In 1983, Congress replaced TEFRA's rate-of-increase limits with a more ambitious and far-reaching reform of Part A reimbursement, the Prospective Payment System (PPS).[1] See 42 U.S.C. 1395ww(d) (1988 & Supp. V 1993). Under the PPS, hospitals are reimbursed for inpatient costs on the basis of prospectively determined federal rates, rather than actual operating costs. 42 U.S.C. 1395ww(d)(1) and (4) (1988 & Supp. V 1993); see 42 C.F.R. 412.60.[2] The PPS provides for largely uniform payment rates calculated on the basis of national and regional reimbursement rates for each patient discharge category, known as a diagnosis-related group. 42 U.S.C. 1395ww(d)(2)-(3) (1988 & Supp. V 1993); see 42 C.F.R. 412.62, 412.63.

Because PPS reimbursement does not depend on an individual hospital's actual costs, reimbursement rates can be determined prospectively. If an individual hospital's costs exceed the prospective federal rates, the PPS requires the hospital to absorb the difference as an operating loss. Conversely, if the hospital's costs are lower than the prospective federal rates, the hospital retains the difference. This

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[1] Several categories of hospitals have been exempted from the PPS and are still reimbursed under the prior TEFRA provisions. See 42 U.S.C. 1395ww(d)(1)(B) (1988 & Supp. V 1993).

[2] In October, 1991, a separate prospective payment system was established for capital costs. See generally 42 U.S.C. 1395ww(g) (1988 & Supp. V 1993); 42 C.F.R. 412.300 *et seq.* This case concerns pre-1991 cost reporting periods and does not involve any dispute over capital costs.

reimbursement scheme was "intended to reform the financial incentives hospitals face, promoting efficiency * * * by rewarding cost[-]effective hospital practices." H.R. Rep. No. 25, 98th Cong., 1st Sess. Pt. 1, at 132 (1983).

In order "to minimize disruptions that might otherwise occur because of a sudden change in reimbursement policy," Congress phased in the PPS by creating a transition period from 1983 to 1987. H.R. Rep. No. 25, *supra*, at 136. The reimbursement controversy in this case concerns that now-expired PPS transition period. During the transition period, inpatient hospital services were reimbursed on the basis of blended rates, which consisted of two components. The first component was a percentage of the prospective federal rate under the PPS. 42 U.S.C. 1395ww(d)(1)(A)(i)(II) and (ii)(II) (Supp. V 1987). The second component, known as the hospital-specific portion (HSP), was a specified percentage of the hospital's "target amount" for the cost reporting period. 42 U.S.C. 1395ww(d)(1)(A)(i)(I) and (ii)(I) (Supp. V 1987). Over the course of the four-year transition period, the portion of the reimbursement amount tied to the prospective rate became progressively larger and the portion tied to the HSP became progressively smaller. The HSP was eventually phased out altogether, and the prospective rate thereafter formed the exclusive basis for PPS reimbursement. 42 U.S.C. 1395ww(d)(1)(C) (Supp. V 1987).

The present case involves the calculation of the HSP's "target amount." To define the "target amount" used during the PPS transition period, Congress borrowed the definition it had used earlier in TEFRA: Congress directed the Secretary to use "the hospital's target amount for the cost reporting

period (as defined in subsection (b)(3)(A) of this section * * *)." 42 U.S.C. 1395ww(d)(1)(A)(i)(I) and (ii)(I) (Supp. V 1987). Thus, to calculate a hospital's "target amount" during the PPS transition period, the Secretary was required to determine the allowable costs during the 12-month reporting period preceding the first TEFRA year, known as the base year, then increase that figure by the specified percentages for subsequent periods. See 42 U.S.C. 1395ww(b)(3)(A) (1982); see page 3, *supra*.

When Congress created the PPS, it provided in 42 U.S.C. 1395ww(d)(5) (1988 & Supp. V 1993) for various exceptions and adjustments, just as it had done earlier when it enacted TEFRA. Congress gave the Secretary similar general authority under the PPS to establish "such * * * exceptions and adjustments to * * * payment amounts under this subsection as the Secretary deems appropriate." 42 U.S.C. 1395ww(d)(5)(I) (Supp. V 1993). That subsection also directs the Secretary to implement a number of specific exceptions and adjustments. 42 U.S.C. 1395ww(d)(5)(A)-(H) (1988 & Supp. V 1993). In contrast to TEFRA's analogous provision, however, Subsection (d)(5) does not direct the Secretary to adjust reimbursement amounts where "extraordinary circumstances" distort the increase in costs for a particular cost reporting period.

The PPS's transition-period reimbursement provisions are implemented in regulations found at 42 C.F.R. 412.70-412.76. Among other things, the regulations specify a limited number of situations in which the "target amount" used to calculate the HSP may be modified to reflect costs other than allowable base-year costs. See 42 C.F.R. 412.71(b)-(c), 412.72(a). Notably, however, the regulations do not authorize

modification of the target amount to take into account cost increases occurring after the base year.

3. Petitioners are 114 Florida hospitals that are seeking increased Medicare reimbursement for the now-concluded PPS transition period. Petitioners claim to have experienced an increase in operating costs beginning in 1984, after the end of the base year used to determine the "target amount" under Subsection (b)(3)(A), due to Florida's imposition of a recurring "Indigent Health Care Program" assessment (Pet. App. 13a-14a). Petitioners sought increased reimbursements on the basis of Subsection (b)(4)(A). The Secretary denied the adjustment requests on the ground that Subsection (b)(4)(A) did not apply to the PPS transition period and that post-base-year cost increases did not qualify for adjustment under the PPS transition-period reimbursement rules.

Petitioners brought suit against the Secretary in the District Court for the Middle District of Florida. The district court referred the case to a magistrate judge, who recommended that the court grant summary judgment in favor of the Secretary. Pet. App. 11a-17a. The district court adopted the magistrate judge's recommendation, *id.* at 7a-8a, and petitioners appealed. The court of appeals affirmed the district court in a *per curiam* opinion, agreeing with the reasoning of the District of Columbia Circuit in *Episcopal Hospital* v. *Shalala*, 994 F.2d 879 (1993), cert. denied, 114 S. Ct. 876 (1994), and the Third Circuit in *Sacred Heart Medical Center* v. *Sullivan*, 958 F.2d 537 (1992). See Pet. App. 3a-4a.

ARGUMENT

The question presented by petitioners in this case is whether 42 U.S.C. 1395ww(b)(4)(A) (1982) was implicitly incorporated into the now-superseded provisions that governed Medicare reimbursement during the PPS transition period from 1983 to 1987. As petitioners concede (Pet. 9), the identical issue was presented two Terms ago in *Episcopal Hospital* v. *Shalala*, 114 S. Ct. 876 (1994), and *Methodist Hospital* v. *Shalala*, 114 S. Ct. 2162 (1994), and this Court denied certiorari on both occasions. The Court should deny certiorari in this case for the same reasons.

1. Our brief in opposition in *Episcopal Hospital* set forth the considerations that militate against review of the issue by this Court.[3] As we explained there in detail, the statute's language, structure, and purpose indicate that the PPS transition-period provisions did not incorporate Subsection (b)(4)(A). Equally important, the legal dispute resolved by the court of appeals concerns the relationship between two now-superseded reimbursement provisions, neither of which applies to cost reporting periods after 1987. The issue that petitioners raise therefore continues to lack the sort of ongoing significance that would warrant review by this Court.[4]

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[3] We have furnished counsel for petitioners with copies of our briefs in opposition in *Episcopal Hospital* and *Methodist Hospital*.

[4] Petitioners point out (Pet. 9, 12) that the Ninth Circuit reached a contrary result in *Community Hospital of Chandler* v. *Sullivan*, 963 F.2d 1206, 1213-1214 (1992). As we explained in our brief in opposition (at 14-15 & n.8) in *Episcopal Hospital* (No. 93-429), however, the Ninth Circuit ruled on the issues

2. Petitioners suggest that the denial of certiorari in *Episcopal Hospital* should not foreclose further review in this case because the Subsection (b)(4)(A) issue was not cleanly presented in that case. Petitioners assert (Pet. 9) that the decision of the court of appeals in *Episcopal Hospital* rested on an independent ground that was not challenged in the certiorari petition—namely, a determination by the court of appeals that the hospitals in *Episcopal Hospital* did not meet the criteria for relief under Subsection (b)(4)(A). The petitioners in *Methodist Hospital* unsuccessfully sought to distinguish *Episcopal Hospital* on the same theory. See Pet. at 3, *Methodist Hospital* v. *Shalala*, 114 S. Ct. 2162 (1994) (No. 93-1449).

Contrary to petitioners' assertion, the court of appeals in *Episcopal Hospital* never determined that the hospitals failed to meet the criteria for relief under Subsection (b)(4)(A). Although the district court in *Episcopal Hospital* had made such a determination, the court of appeals did not reach that issue. Instead, the court of appeals terminated its analysis with the conclusion that Subsection (b)(4)(A) did not apply to the PPS transition period. That conclusion rendered irrelevant the further issue whether the

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without benefit of briefing by the Secretary (since the issues had not been raised and therefore appeared to have been waived), and the government chose not to seek certiorari in that case because of the limited significance of the issue. Moreover, as the magistrate judge in this case observed (Pet. App. 16a-17a), the Ninth Circuit in *Community Hospital of Chandler* failed to address certain critical points, including the principle of deference to the Secretary's interpretation and the significance of the separate exemption and adjustment provisions under the PPS system.

hospitals met Subsection (b)(4)(A)'s requirements. See 994 F.2d at 883-884.[5] As a result, the petition in *Episcopal Hospital*, as well as the subsequent petition in *Methodist Hospital*, squarely presented the same Subsection (b)(4)(A) issue that is being advanced in the current petition.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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[5] The court of appeals also addressed the issue whether the Secretary was otherwise obligated, apart from Subsection (b)(4)(A), to grant the hospitals the adjustments they sought. See 994 F.2d at 884. It concluded that she was not. *Ibid.*